# BRITISH CARDIAC SOCIETY NEWSLETTER

Many members will have received the letter from Dr Kenneth Calman, the Chief Medical Officer to the Department of Health, on the implementation of the report Hospital doctors: training for the future.

Dr Calman wrote that Ministers had agreed to the full implementation of the report, which encourages the development of a consultant based service. This will shorten training from an average of 12 years to an average of 7 years with more structured and intensive training. The registrar and senior registrar grades will be unified and the finishing point of specialist training will be defined by the Certificate of Completion of Specialist Training (CCST).

Dr Calman recognised that the present rate of expansion of consultant posts (2%) needs to be increased. Some existing senior registrar appointments will be upgraded to consultant posts. He emphasised two important conditions: firstly, that there will be no overall increase in NHS resources to fund the changes and, secondly, the need to move away from existing medical staffing policies towards more flexible measures that emphasise "local decision making and priorities".

The NHS Management Executive will be issuing an implementation plan for consultation, but the responsibility for deciding content, direction, and criteria for specialist training rests with individual specialist Royal Colleges and hence through to the SAC in Cardiovascular Medicine and our Training and Manpower Committee. It is important to recognise that the minimum length of training programmes is being reduced but it remains to be seen how much flexibility there will be, especially in terms of funding of the training programmes through the postgraduate deans. During 1994 the General Medical Council will be consulting on the content of general professional training before specialist training.

The letter recognises many difficulties in achieving the change, including the period immediately after the award of a CCST and the introduction of a national numbering system of trainees. These issues are being taken forward by a working group and an implementation steering group. Furthermore, three expert groups are looking at the training of doctors in academic and research medicine, the training of overseas doctors, and the training of general practitioners. Dr Calman envisages that the change to the new structure will be completed within six years. There are many important changes ahead and the Training and Manpower Committee will be working with the British Cardiac Society Council to ensure that six years from now we have excellent training programmes with appropriate numbers of trainees and adequate numbers of consultants to provide the level of specialist care that patients with cardiac disease have a right to expect. Please send any views you have to the British Cardiac Society.

The following two reports from the Joint Audit Committee and the European Society of Cardiology make it clear that clinical guidelines will play an increasingly important part in everyday practice—we must all be involved.

# Joint Audit Committee BCS/RCP London

David de Bono writes in defence of clinical standards: but not of cookbooks:

"The NHS Management Executive has recently (and some would say belatedly) become interested in the concept of writing clinical standards into purchaser-provider contracts. Among documents recently circulated to purchasers as possible source material on which to base such standards was a paper on audit guidelines and clinical standards in stable angina prepared as a summary of a workshop held under the auspices of the Joint Audit Committee of the British Cardiac Society and the Royal College of Physicians of London. The Joint Audit Committee has since held a further workshop on acute myocardial infarction and intends shortly to hold workshops on heart failure, arrhythmias, and valvar heart disease. Is this an attempt to curb the rich diversity of British cardiological practice by imposing rigid guidelines or cookbook protocols? Emphatically not! There is increasing recognition by all parties, not least by purchasers, that the only guidelines likely to be followed—and therefore effective-are those drawn up locally with the involvement of all interested parties including general practitioners with a full understanding of local problems and resources. The two main objectives of the Joint Audit Committee summaries are firstly to provide a brief but accurate description of the clinical condition and a synopsis of recent clinical trial data and second to identify essential features that need to be recorded so that clinical practice can be audited. If clinicians can use this material to help them draw up local guidelines, then our aim will have been fulfilled. In practice, no one can or should expect absolute compliance even with local guidelines: this would be robotics not medicine. On the other hand, clinicians who depart from locally agreed guidelines should be prepared to justify their action and, even more important, to record their results. When I started in cardiology I was taught to use 8 gauge catheters, always to do a left ventricular angiogram, always to heparinise the patient, and to keep catheter patients in hospital overnight (if not for three or four days). I now do none of these. Changes in management of myocardial infarction, arrhythmias and heart failure have been even more spectacular. But there is no point in being an innovator unless process and outcome are properly recorded so that they can be independently checked, compared with conventional wisdom and, if better, communicated efficiently to others. Purchasers will increasingly seek to write audit funding into individual contracts rather than to deliver it as a lump sum; they can be educated to see properly audited innovation as being essential to their own interests as well as those of the provider."

# **European Society of Cardiology**

Philip Poole-Wilson writes: "Some of you are involved in working groups that prepare guidelines, academic comments or policy statements on areas of interest in cardiology. The Board of the European Society of Cardiology has clarified how these activities should be classified. A task force is established by the board to prepare recommendations or guidelines. Task forces can be proposed to the board by working groups, national societies, or others. The final document needs endorsement by the Board of the European Society Cardiology and will be published in the European Heart Journal. Study groups can be established by working groups of the European Society of Cardiology to look into specific topics and to prepare opinions and recommendations. These reports reflect the opinions of the study groups and working group. Ideally reports from study groups should be submitted to the European Heart Journal and they almost certainly will be subjected to the normal reviewing process. I do hope that many of you will join task forces or study groups. If there are topics that you think should be evaluated in the context of a working group of the European Society of Cardiology do suggest that to the chairmen of those working groups.

#### Forthcoming meetings

Jarda Stark is due to give his Tudor Edwards Lecture entitled "Quo vadis paediatric cardiac surgery" on 2 June 1994 at 5.00 pm at the Royal College of Surgeons of England, 35/43 Lincoln's Inn Fields, London. For further information telephone 071 405 3474.

A second meeting on Cardiovascular Disease Prevention will be held on the 19–22 July 1994 at the Conference Centre, Kensington Town Hall, London. Please contact Hampton Medical Conferences Limited, Hofer House, 185 Uxbridge Road, Hampton, Midd.esex (tel: 081 783 0810) for further information.

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# NOTICE

The 1995 Annual Meeting of the **British** Cardiac Society will take place at the Conference Centre, Harrogate, West Yorkshire from 23 to 25 May.

# CORRECTION

Increase in plasma β endorphins precedes vasodepressor syncope D R Wallbridge, H E MacIntyre, C E Gray, M A Denvir, K G Oldroyd, A P Rae, S M Cobbe. We regret that owing to a printers' error all four figures in this article in the May issue (Br Heart J 1994;71:446-8) appeared in the wrong order and with wrong legends. The corrected version of the article is reprinted on pages 597-599 of this issue.

Br Heart J 1994;71:600-602

# **VOLUME 71: AUTHOR INDEX**

S = British Society of Echocardiography Supplement 1994, L = letter, E = editorial, R = review, T = te-	chnique, V = viewpoint
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S = British Society of Echocardiography Supplement	at 1994, $L = letter$ , $E = editorial$ , $R = review$ , $I = t$	ecnnique, v = viewpoint
A	Channer KS, 146	Findlay IN, 401 (E)
Abenhaim L, 303 (L)	Channon K, 484	Firmin RK, 566
Aber CP, 129	Cheng TO, 107 (L)	Fitzpatrick AP, 274
Agata Y, 182	Chennells PM, 363	Flapan AD, 515
Akhras F, 341	Chierchia S, 166	Fletcher S, 141
Allan L, 232	Clark AL, 162, 528	Fontaine G, 215
Allan LD, 70	Clarke A, 490 (L)	Fontaliran F, 215
Allen JW, 454	Clarke KW, 38, 584	Foran JPM, S31 abs
Altman R, 151	Cleland JGF, 109, 206, 224, 304, 399, 490,	Forbat SM, 489
Anagnostou E, S31 abs	596 Contact 45	Forfar C, 268
Andersen C, 419	Coady A, 45	Fort S, 354
Anderson MH, 16	Coats AJS, 162, 528 Cobbe S, 492	Fox K, 406 (E) Fox KAA, S32 abs
Andersson B, 261	Cobbe SM, 446 (correction, 597), 511	Foy SG, 30
Angelini GD, 382 Antoniadis A, 536	Cochrane D, 531	Fragasso G, 166
Appleby M, S33 abs	Coltart JD, 22	Fraser A, S6
Arnold R, 588	Contaido F, 287	Fraser AG, S31 abs, S32 abs, S35 abs, S36 abs
Axford JS, 459	Cooke R, S31 abs	Frees U, 254
Azhar M, 224	Cooke RA, 561	Frenneaux MP, 554
1 1111111 11111	Cooper IC, 22	Furniss SS, 386
В	Cowell RPW, 569	
Bailey CR, 349	Cox A, 431	G
Bain H, 102	Crake T, 481	Galderisi M, 287
Balcon R, 7, 492	Creamer JE, 316	Gamra H, 454
Banner NR, 431	Crook D, 41	Garofalo M, 287
Banning AP, S35 abs, S36 abs	Cross SJ, 311	Garratt CJ, 307 (E)
Barbir M, 408	Crowley JJ, S35 abs	Garthwaite P, 311
Barbosa V, 249	Crowther A, 22, 229	Gatzoulis MA, 579
Barlow C, 268	Crozier IG, 30	Ge J, 572
Barzilai B, 404 (E)	Cullen S, 479	Gerber T, 572
Bashir Y, 119 (R), 322	Cunningham D, 213 (E), 401 (E)	Gershlick AH, 7, 510
Bateman J, 268	Currie J, 368	Gerstenblith G, 249 Gerundini PP, 166
Becker AE, 507	Curry PVL, 561	Gibbs JL, 487
Bellotti G, 249	D	Gibbs JSR, 372
Benti, 166	D Dardas P, S35 <i>abs</i>	Gibson DG, 541, 548
Besana C, 166	Dargie HJ, 213 (E), 401 (E)	Gill JS, 322
Bexton RS, 202, 395	D'Avanzo B, 468	Glatz JFC, 135
Blackburn ME, 487	Davey PP, 268	Godman MJ, 63
Blake D, 212	Davies DW, 481	Godsland IF, 41
Blomstrom-Lundqvist C, 215	Davies MJ, 214	Goggin PM, 437
Bloom SR, 305 (E) Bloomfield P, 515	Davies SW, 7	Gold RG, 395
Bode C, 242	de Albuquerque CP, 249	Gomersall LN, 368
Bolton CH, 293	de Bakker JMT, 170	Görg G, 572
Borri A, 166	de Belder MA, S15, 209 (E)	Grädel E, 449
Bourke JP, 386	de Bono D, 504 (R)	Grady RM, 370
Boyle D, 492	de Divitiis O, 287	Graham TR, 354
Brecker SJD, 548	de Jongste MJL, 413	Grant SCD, 76, 82
Bridges ND, 370	de Simone G, 287	Gray CE, 446: correction, 597
British Society of Echocardiography Supple-	Dean JW, 366, 385	Gray D, 38, 474, 584
ment 1994, S1-36	Defauw JJAMT, 170	Greenhalgh RM, 45
Brooks NH, 76, 82	Denvir MA, 446: correction, 597	Griffith MJ, 202, 395
Brown AS, 540	Di Biase G, 287	Grossi A, 109 (L)
Bryan AJ, 382, 404 (E)	Dickie A, 311	Groves A, 232
Bucknall CA, 378	Dietz R, 254	Grubb NR, S32 abs
Buller NP, 372	Dodds PA, S34 abs	Grünig E, 242 Guiraudon GM, 170
Bu'Lock FA, 358	Doig JC, 386	Gurfinkel E, 151
Burckhardt D, 449	Dolci A, 109 (L)	Gustafsson LE, 282
Burkart F, 449	Donatelli F, 109 (L)	Gustaisson Las, 202
Burns JE, 63	Dritsas A, S32 abs Dubrey S, 187, 341	Н
	Dunn FG, 92	Haaksma J, 413
C	Durrington PN, 125, 316	Hackson G, S31 abs
Camerini F, 215	Dyer PA, 76	Hall RJC, S31 abs, S32 abs, S35 abs, S36 abs
Camm AJ, 3 (E), 16, 96, 322, 437, 554	Dyke L, 334	Hamm C, 242
Camm J, 521	Dymond DS, 334	Hampton JR, 38, 474, 584
Campanella C, S32 abs	Dymona 20, 33 1	Handler CE, S31 abs
Campbell NPS, 531	E	Hardman T, 341
Campbell RWF, 386, 508 (R)	Egashira K, 181	Hargreaves M, 484
Caplin J, 490 (L) Caplin JL, 129	Eleftherakis N, S34 abs	Hart G, 268
Ceconi C, 422	Erbel R, 572	Haude M, 572
Celentano A, 287	Ewing DJ, 515	Hausdorf G, 89
Cerutti S, 422	-	Hautvast RWM, 413
Chakraborty R, 29	F	Hedner T, 261
Chamberlain D, 492	Farrell T, 521	Henein MY, 541
Chamberlain-Webber R, 191, 274	Fei L, 16, 322	Herlitz J, 238
Chambers J, S6	Feng QP, 261	Hermens WT, 135 Higenbottam T, 303 (L)
Chambers JB, S31 abs, 561	Fenton AC, 566	Higham PD, 508 (R)
Chan K-Y, 70	Findlay I, 213 (E)	Auguani A 20, 200 (A)

Author Index 601

Rigman DJ, 45			
Hillies AD, 51 Hiroska N, 182 Hiroska Y, 181 Levy RD, 78, 82 Horoska Y, 181 Levy RD, 78, 82 Horoska Y, 181 Levy RD, 78, 82 Hologe B, 254 Horoska Y, 181 Levy RD, 78, 82 Hologe B, 254 Horoska Y, 181 Levy RD, 78, 82 Hologe B, 254 Levy RD, 78, 82 Levy	Higman DJ, 45	Lee HS, 311	Northfield TC, 437
Hirabit S, 182	Hillege HL, 413	Lefroy DC, 481	Nowatari M, 182
Hirofox Y, 181	Hilless AD, 51	Leslie RDG, 341	
Hirolo N, 1, 18   Levy RD, 7, 6, 82	Hiraishi S, 182	Levy J, 437	0
Part	Hirooka Y, 181	Levy RD, 76, 82	
Halahamaton, A., 238	Hiura K, 182	Lewis CT, 354	
Hother p. 1, 19		Lewis NP, S36 abs	•
Holder Mil.   1972   Lindy   1963	Hoberg E, 254	Lie KI, 413	. <del>.</del>
Honey 1, 19	Holden MP, 202	Lim R, 334	_ T
Hoogen   17   17   18   18   19   19   19   19   19   19	Hole P, 419	Lindsay HSJ, 363	
Littlet N. 40   Littlet N. 4	Hooper J, 177	Lip GYH, 92	
Howey S, 129	Horsburgh RJ, 30	Littler WA, 303 (L)	
Hunt I. 316 Hunter S. 102, 492, 520 Hynd J. 341 Luner S. 102, 492, 520 Los K. S. 462 Low CJS, 30 Los K. S. 462 Low CJS, 30 Coholm J. 419 Luner S. 102, 492, 520 Lynch M., 303 (L) Lune Hynd, 202 Lynch M., 303 (L) Lune Hynd, 303 (L) Lune Hynd, 202 Lynch M., 303 (L) Lune Hynd, 303 (L) Lune H	Howey S, 129	Lo SSS, 341	and the second s
Hunter S, 102, 492, 520   Lack S, 462   O'Sallivan JO, 102 (T)	Hunt L, 316	Lombardi F, 1 (E)	
Hynd    Java   Low CIS; 30	Hunter S, 102, 492, S20		
Lundberg JM, 261 Lundbe	Hynd J, 341		
Lundell BPW, 282   Pagent M, 1 (E)   Pagent M,		Lundberg JM, 261	Oxilo) 11, 419
Distribution   Lynch M, 303 (L)	I		
Bram H, 30   Bram H, 30   Bram S, 535 abs, 536 abs   McClements BM, 531   Biodromits B, 536   McClements BM, 531   McClements BM, 531   Biodromits B, 536   McLen K, 64   McLen KA, 146   Partnersilves B, 532 abs   Malairy A, 538   Part W, 539, 538   Part W, 540, 533 abs   Part W, 540, 534   Partnersilves B, 532 abs   Partnersilves B, 532 abs   Partnersilves B, 532 abs   Partnersilves B, 533 abs   Partnersilves B, 532 abs   Partnersilves B, 533 abs   Partnersilves B, 534 abs   Partnersilves B, 535 abs   Partnersilves	Ikonomidis I, S34 abs	Lynch M, 303 (L)	
Mo-Clement BM, 531	Ikram H, 30	·	- , ,
Isley CDJ, 569   McCamb JM, 501 (E)   Parker JD, 6, 206, 304, 399, 490, 596     Ingram A, 274   MacIngry HE, 446: correction, 597     Ingram A, 274   MacIngry HE, 446: correction, 597     Ingram W, 170   MacIngry HE, 248   Missuar H, 34     Ingram W, 170   MacIngry HE, 249   Missuar H, 34     Ingram W, 170   MacIngry HE, 446: correction, 597     Ingram W, 170   MacIngry HE, 248   Missuar H, 34     Ingram W, 170   MacIngry HE, 248   Missuar H, 34     Ingram W, 170   MacIngry HE, 248   Missuar H, 34     Ingram W, 170   MacIngry HE, 242   MacIngry HE, 242   MacIngry HE, 242     Ingram W, 170   MacIngry HE, 242   MacIngry HE, 242   MacIngry HE, 242     Ingram W, 170   MacIngry HE, 242   MacIngry HE, 242   MacIngry HE, 242     Ingram W, 170   MacIngry HE, 242   MacIngry H	Ikram S, S35 abs, S36 abs	M	
Isley CD, 569   McComb   M, 501 (E)   Parker D], 6, 206, 304, 399, 490, 596	Iliodromitis E, 536	McClements BM, 531	
Blaley CDJ, 569   McHaffe DJ, 51   Parker, 1, 109, 492   Parker,	Ilsley C, 408	•	
Jagran A, 274   MacInsyr: HE, 446: correction, 597   MacRenna W1, 215, 322, 459, 554   MacRenna W1, 215, 322, 325, 325, 325, 325   MacRenna W1, 215, 322, 325   MacRenna W1, 325	Ilsley CDJ, 569	<del>_</del> _ <del>_</del> _ <del>_</del> _ · · · · · · · · · · · · · · · · · ·	Parker J, 109, 492
Inou T, 181	Ingram A, 274		Parthenakis F, S32 abs
In M. 87			Patel N, 431
Izzat MB, 382   McLaughin NB, 386   McLaus KA, 146   Paul VE, 96, 569	Ito M, 87		Patton H, 431
McLead KA, 467  Jasrsma W, 170  McLead KA, 487  MacNeill A, 232  Perrins EJ, 363  Perry BA, 334 abs  Perry RA, 344  P	Izzat MB, 382	· ·	Paul VE, 96, 569
Jackson M., 558, 588 Jemings K., 311 Jackson M., 558, 588 Jemings K., 311 Joffe HS,, 338 Jemings K., 311 Joffe HS,, 338 Joffe HS,, 348	•		
Jaarsm W, 170  Jackson M, 558, 588  Kalb-Fillo R, 249  Karinical L, 422  Meran M, 56  Marcatt M, 166  Marchart M	J		Pentecost BL, 303 (L)
Jackson M., 558, 568  Jackson M., 558, 568  Jackson M., 558, 568  Jeffrey R., 368  Jennings K., 311  Jennings K., 311  Jones R., 531 abs, 532 abs, 378  Joffe J. S., 358  Jorde J. S., 358  Jore			Perrins EJ, 363
Jeffrey R, 368			Perry BA, S34 abs
Jenning K, 311		* *	Perry RA, S34 abs
Jewitt DE, S33 abs, S35 abs, 378			Petersen MEV, 274
Joffe HS, 358	· · ·		Pfisterer M, 449
Jones R, S36 abs   Marcant M, 166   Polonicekil, 322, 521     Jones RA, S31 abs, S32 abs, S36 abs   Marchant B, 329   Post W, 440     Jones RA, S31 abs, S32 abs, S36 abs   Marchant B, 329   Post W, 440     Jones RA, S31 abs, S32 abs, S36 abs   Marchant B, 329   Post W, 440     Judge K, 96   Martin M, S33 abs   Post W, 440     Martin M, S33 abs   Marchant B, S32 abs, S36 abs     Kabahaii E, S32 abs   Masani N, S36 abs   Masund T, 156     Kabahaii E, S32 abs   Masund T, 156   Polonicovich L, S33 abs     Kaijama G, 34   Masund T, 156   Polonicovich L, S33 abs     Kaijama G, 34   Masund T, 156   Polonicovich L, S33 abs     Kaijama G, 34   Masund T, 156   Polonicovich L, S33 abs     Kaijama G, 34   Masund T, 156   Polonicovich L, S33 abs     Kaijama G, 34   Masund T, 156   Polonicovich L, S33 abs     Kaijama G, 34   Masund T, 156   Polonicovich L, S33 abs     Kaijama G, 34   Masund T, 156   Polonicovich L, S33 abs     Karlon BW, 238   Masund T, 156   Rempt A, S17   Polonicovich L, S33 abs     Karlon BW, 238   Masund T, 156   Rempt A, S17   Ranker V, S18     Karlon BW, 238   Masund T, 156   Rempt A, S17   Ranker V, S18   Ranker V, S18     Karlon BW, 238   Masund M, 437   Ranker V, S18   Ranker V, S18     Kangana H, 70   Mile PG, 354, 366   Res DHE, 459   Redington A, 479     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 70   Mile PG, 354, 366   Res DHE, 459     Kingma JH, 7	· ·		Pileggi F, 249
Jones R, S31 abs, S32 abs, S36 abs   Marcatti M, 166   Polonick IJ, 322, 521   Polones RA, S31 abs, S32 abs, S36 abs   Marks W, 293   Power Wilson PA, 162, 391, 541   Post W, 440   P	•		Pinna G, 422
Jones RA, S31 abs, S32 abs, S36 abs   Marchart B, 329   Poole-Wilson PA, 162, 391, 541   Poole-Wi			Poloniecki J, 322, 521
Joshi J. S32 abs   Marks V. 293   Post W, 440   Judge K, 96   Martin M, S33 abs   Powell JT, 45   Pruvulovich L, S33 abs   Pruvulovich L, S34 abs   Pruvulovich L, S35 abs   Pruvulovich L, S34 abs   Pruvulovich L, S35 ab			Poole-Wilson PA, 162, 391, 541
Judge K, 96  Martin M, S33 abs Martinelli L, 422  K  Kabahaji E, S32 abs Kabahaji E, S32 abs Kajirama G, 34  Kalii-Filho R, 249  Kariswa S, 34  Karish J, 16, 22  Mewa AD, 316  Kating PJ, 322, 459  Keening PJ, 322, 459  Kemp M, 177  Kenny A, 57, S35 abs  Khumin NS, 30  Kickley H, 113 (E)  Kisolo J, S28  Kichiner D, 558, 588  Kichiner B, 129  Kooch L, 572  Kooten W, 440  Moususy IP, 202, 395  Kreidich I, 334  Kremastinos DT, 536  Koulakowski P, 521  Kumar EB, 129  Kunar A, 79  Murray A, 366  Kulakowski P, 521  Kumar A, 79  Kumar EB, 129  Kunar A, 79  Murray A, 366  Kulakowski P, 521  Kumar A, 79  Murray A, 366  Kulakowski P, 521  Kumar A, 79  Kumar EB, 129  Kunar A, 79  Murray A, 366  Kulakowski P, 521  Kumar EB, 129  Kunar A, 79  Murray A, 366  Kulakowski P, 521  Kumar EB, 129  Kunar A, 79  Murray A, 366  Kulakowski P, 521  Kumar EB, 129  Kunar A, 79  Murray A, 366  Kulakowski P, 521  Kumar EB, 129  Kunar A, 79  Kumar EB, 129  Kunar A, 79  Kumar EB, 129  Kunar A, 79  Murray A, 366  Kulakowski P, 521  Kumar EB, 129  Kunar B, 120  Kunar B, 120  Kunar B	· ·		Post W, 440
Martinelli I, 422			Powell JT, 45
K Ababhaji E, S32 abs Masani ND, S31 abs, S32 abs, S36 abs Masani ND, S31 abs, S32 abs, S36 abs Asiiyama G, 34 Kalii-Fiho R, 249 Karakawa S, 34 Karer O, 242 Karakawa S, 34 Karrer O, 242 Karlasis D, 16, 22 Karisis D, 16, 22 Karisis D, 16, 22 Karus HA, 242, 254 Keeling PJ, 322, 459 Keep M, 177 Kenny A, 57, S35 abs Khaghani A, 408 Khurmi NS, 30 Kickley H, 113 (E) Kroilyanou V, S34 abs Kishiner D, 558, 588 Kichiner D, 558, 588 Kichiner D, 558, 588 Kichiner D, 572 Kouchouko NT, 404 (E) Krematsin DT, 536 Kouchouko NT, 404 (E) Krematsin DT, 536 Kulakowski P, 521 Kumar A, 79 Kumar EB, 129 Kushawaha SS, 431 Kyriakides ZS, 536  N Nagata K, 34 Kushan NS, 31 Kyriakides ZS, 536 N Nagata K, 34 L L A Rovere MT, 422 La Vecchia C, 468 Labird, X, 31 Lange PE, 89 Langer I, 449 Lau FYK, 454 Lauford, P, 56 Lawson-Matthew P, 146 Layton C, 7 Noble MIM, 341	Jungo 15, 20		Pruvulovich L, S33 abs
Kabahaji E, S32 abs	к		Purkiss SF, 354
Kaijyama G, 34			Pye M, 511
Kalil-Filho R, 249			•
Karakwa S, 34         Matsuura Y, 34         Quinn AC, 511           Karlson BW, 238         Mautner B, 151           Karrer O, 242         MBewu AD, 316         R           Katrus HA, 242, 254         Meeran K, 305 (E)         Ra ea P, 446: correction, 597           Katus HA, 242, 254         Mendall MA, 437         Raftery EB, S31 abs           Keeling PJ, 322, 459         Meyer J, 572         Raftery EB, S31 abs           Kemp M, 177         Meyler PWJ, 413         Rankin I, 191           Knaphani A, 408         Michala L, S33 abs         Rankin I, 191           Khupani A, 408         Michelakakis N, 536         Ray SG, 395           Kiumani NS, 30         Mills PG, 354, 366         Redington A, 479           Kinowski W, 449         Mishra M, 331 abs         Redington A, 479           Kirolivanou V, S34 abs         Misumi I, 156         Remppis A, 242           Kitchiner D, 558, 588         Mitwa Y, 156         Remppis A, 242           Kleine AH, 135         Molineaux N, 437         Richine A, 492           Kneight C, 406 (E)         Monaghan MJ, S1, S33 abs, S35 abs, 540         Richardson M, 146           Kooter L, 572         Mortara A, 422         Richardson M, 146           Kreidich I, 334         Mukai J, 34         Rosin MD, 193           Kreidich I, 334	1.1		0
Karrer O, 242			-
Karries D, 16, 22 Meeran K, 305 (E) Rae AP, 446: correction, 597 Katus HA, 242, 254 Mendall MA, 437 Raftery EB, S31 abs Keeling PJ, 322, 459 Meyer J, 572 Ranjadayalan K, 329 Kemp M, 177 Meyler PWJ, 413 Ranjadayalan K, 329 Kemp M, 177 Meyler PWJ, 413 Ranjadayalan K, 329 Kenp M, 177 Menny A, 57, S35 abs Khaghani A, 408 Michalakais N, 536 Rauch B, 254 Rhurmi NS, 30 Mickley H, 113 (E) Redington A, 479 Kingma JH, 170 Mills PG, 354, 366 Khurmi NS, 30 Mickley H, 113 (E) Redington A, 479 Kingma JH, 170 Mills PG, 354, 366 Reso DHE, 459 Kirolivanou V, S344 abs Kirolivanou V			Quilli AC, 311
Katritsis D, 16, 22 Katus HA, 242, 254 Keeling PJ, 322, 459 Keeling PJ, 322, 459 Keeling PJ, 322, 459 Kemp M, 177 Meyer PWJ, 413 Khanin A, 408 Kharmin NS, 30 Kinghani A, 408 Khurmin NS, 30 Kingma JH, 170 Misle PG, 354, 366 Rees DHE, 459 Kisiblo J, S28 Mischell A, 408 Kisenia J, 156 Kissib J, S28 Mischell A, 408 Kitchiner D, 558, 588 Mijao Y, 156 Kisiblo J, S28 Michell A, 408 Kitchiner D, 578, 588 Kleine AH, 135 Molineaux N, 437 Koh, 1, 156 Koh L, 572 Monaghan MJ, S1, S33 abs, S35 abs, 540 Koh L, 572 Koster RW, 440 Moratra A, 422 Koster RW, 440 Moratra A, 422 Koster RW, 440 Mounsey JP, 202, 395 Kouchoukos NT, 404 (E) Mounsey JP, 202, 395 Kouchoukos NT, 404 (E) Mounsey JP, 202, 395 Kullah J, 334 Mukai J, 34 Kremastinos DT, 536 Kuller W, 242, 254 Mullahy D, 406 (E) Kosano GMC, 541 Rosano			
Katus HA, 242, 254 Keeling PJ, 322, 459 Keening PJ, 372 Kenny A, 57, S35 abs Kemp M, 177 Meyler PWJ, 413 Kenny A, 57, S35 abs Khaghani A, 408 Michalakis N, 536 Khurmi NS, 30 Michalakis N, 536 Khurmi NS, 30 Michelakis N, 536 Khurmi NS, 30 Mishar M, 831 abs Kinigma JH, 170 Mills PG, 354, 366 Kinigma JH, 170 Mills PG, 354, 366 Kinigma JH, 170 Mills PG, 354, 366 Redington A, 479 Rees DHE, 459 Rees DHE, 459 Reington A, 479 Rese DHE, 459 Reington A, 479 Rese JHE, 459 Reval K, 492 Ritchiner D, 558, 588 Misumi I, 156 Reington A, 492 Ritchiner D, 558, 588 Misumi N, 437 Rollineaux N, 438 Reid J, 515 Rempis A, 242 Reval K, 492 Ritchardson M, 146 Richardson M, 146 Richardson M, 146 Richardson PJ, 533 abs Robotham KF, 534 abs Rollineaux N, 437 Rollineaux N, 438 Rollineau		-	R
Keeling PJ, 322, 459 Kemp M, 177 Kemp M, 177 Kenny A, 57, S35 abs Khammi NS, 30 Khalis L, S33 abs Khaghani A, 408 Khurmi NS, 30 Mickley H, H13 (E) Ray SG, 395 Kingma JH, 170 Mills PG, 354, 366 Rees DHE, 459 Kirolivanou V, S34 abs Kirolivanou V, S34 abs Kitchier D, 558, 588 Mishali I, 156 Kleiner AH, 135 Molineaux N, 437 Kleiner AH, 135 Molineaux N, 437 Kleiner AH, 135 Molineaux N, 437 Kleiner AH, 135 Koch L, 572 Koster RW, 440 Moss J, 45 Kouchoukos NT, 404 (E) Kouchoukos NT, 404 (E) Kouchoukos NT, 536 Kubler W, 242, 254 Kulakowski P, 521 Muraddu GF, 287 Kumar EB, 129 Muraddu GF, 287 Kumar EB, 129 Kumar SB, 31 abs Nagata K, 34 Nagata M, 87 La Rovere MT, 422 La Vecchia C, 468 Labiri A, S31 abs Langer P, 89 Neibson JM, 515 Nagata K, 468 Layon C, 7 Noble MIM, 341  Respondents Sandray GB, 193 Salamoro, 1, 156 Sanderson JE, 136 Salamoro, 1, 156 Sanderson JE, 136 Salamoro, 1, 156 Sanderson JE, 137 Salamoro, 1, 156 Salamoro, 1, 156 Sanderson JE, 136 Salamoro, 1, 156 Sanderson JE, 137 Salamoro, 1, 156 Salamoro, 1,			Rae AP, 446: correction, 597
Kemp M, 177 Kenny A, 57, S35 abs Khaghani A, 408 Michelis L, S33 abs Khurmi NS, 30 Mickley H, 113 (E) Kiowski W, 449 Mish PG, 354, 366 Kiowski W, 449 Mishra M, S31 abs Kirolivanou V, S34 abs Kirolivanou V, S34 abs Mixchell A, 408 Kirichiar D, 558, 588 Kleine AH, 135 Molineaux N, 437 Knight C, 406 (E) Monaghan MJ, S1, S33 abs, S35 abs, 540 Koch L, 572 Mortara A, 422 Kottchoukos NT, 404 (E) Koch L, 572 Mortara A, 422 Kottchoukos NT, 404 (E) Kreidieh I, 334 Kremastinos DT, 536 Kubler W, 242, 254 Kulakowski P, 521 Mureddu GF, 287 Kumar EB, 129 Kumar A, 79 Kumar EB, 129 Kushwaha SS, 431 Kyriakides ZS, 536 N Nagata K, 34 Nakagawa M, 87 La Rovere MT, 422 La Vecchia C, 468 Lahiri A, S31 abs Lange PE, 89 Langer I, 449 Lauvon-Matthew P, 146 Layon C, 7 Nobel Mills A, 368 Noble MIM, 341	TT 1: DT 000 450	· · · · · · · · · · · · · · · · · · ·	
Kenny A, 57, S35 abs         Michalis L, S33 abs         Rankn I, 191           Khaghani A, 408         Michelakakis N, 536         Rauch B, 254           Khurmi NS, 30         Mickley H, 113 (E)         Redington A, 479           Kiomski W, 449         Mills PG, 354, 366         Redington A, 479           Kirolivanou V, S34 abs         Misumi I, 156         Remppis A, 242           Kirsbio J, S28         Mitchell A, 408         Remppis A, 242           Kitchiner D, 558, 588         Miyao Y, 156         Remppis A, 242           Kitchiner D, 558, 588         Miyao Y, 156         Remppis A, 242           Kitchiner D, 558, 588         Miyao Y, 156         Reval K, 492           Kleine AH, 135         Molineaux N, 437         Richards AM, 30           Knight C, 406 (E)         Montara A, 422         Richardson M, 146           Koch L, 572         Mortara A, 422         Richardson M, 146           Kouchoukos NT, 404 (E)         Mouse J, 45         Robotham KF, S34 abs           Kreidieh I, 334         Mukai J, 34         Roson GMC, 541           Kremastinos DT, 536         Mulcahy D, 406 (E)         Roson GMC, 541           Kumar A, 79         Muray A, 386         Ross I, 311           Kumar A, 79         Muray A, 366         Rosumar M, 17           Rumar EB,		* , **	Ranjadayalan K, 329
Khaghani A, 408 Khurmi NS, 30 Khurmi NS, 30 Khurmi NS, 30 Kingma JH, 170 Mils PG, 354, 366 Keeington A, 479 Kiowski W, 449 Mishra M, S31 abs Kirolivanou V, S34 abs Misumi I, 156 Kisslo J, S28 Mitchell A, 408 Kitchiner D, 558, 588 Miyao Y, 156 Kleine AH, 135 Molineaux N, 437 Knight C, 406 (E) Monaghan MJ, S1, S33 abs, S35 abs, 540 Koch L, 572 Mortara A, 422 Koster RW, 440 Moss J, 45 Kouchoukos NT, 404 (E) Mounsey JP, 202, 395 Kouchoukos NT, 404 (E) Mounsey JP, 202, 395 Kübler W, 242, 254 Mulkai J, 34 Kulakowski P, 521 Mureddu GF, 287 Kulakowski P, 521 Mureddu GF, 287 Kumar A, 79 Murray A, 386 Kulakowski P, 521 Murray RG, 193 Kushwaha SS, 431 Kyriakides ZS, 536 N L La Rovere MT, 422 La Vecchia C, 468 Natagaawa M, 87 La Rovere MT, 422 La Vecchia C, 468 Natagaawa M, 87 Lange PE, 89 Neilson JM, 515 Saikawa T, 87 Sakamot T, 156 Saltissi S, S15 Sanderson JE, 413, 490 (L) Sanderson JE, 131, 490 (L) Sanderson JE, 141, 490 (L) Sanderson JE, 141, 490 (L) Sanderson JE, 141	•		Rankin I, 191
Khurmi NS, 30 Kingma JH, 170 Kingh C, 449 Kirchiner D, 558, 588 Misumi I, 156 Rees DHE, 459 Recid J, 515 Reid J, 516 Remppis A, 242 Reval K, 492 Richards AM, 30 Kinght C, 406 (E) Monaghan MJ, S1, S33 abs, S35 abs, 540 Richards AM, 30 Richards AM, 40 Richards AM, 40 Richards AM, 40 Richards AM, 40			Rauch B, 254
Kingma JH, 170 Kiowski W, 449 Kiowski W, 449 Kirolivanou V, S34 abs Kirolivanou V, S34 abs Kirshivanou V, S34 abs Kisslo J, S28 Kitchiner D, 558, 588 Kileine AH, 135 Knight C, 406 (E) Koh L, 572 Monaghan MJ, S1, S33 abs, S35 abs, 540 Koch L, 572 Mortara A, 422 Koster RW, 440 Kouchoukos NT, 404 (E) Kreidieh I, 334 Kremastinos DT, 536 Külakowski P, 521 Kumar A, 79 Kumar A, 79 Kumar A, 79 Kumar A, 79 Kumar BB, 129 Kushwaha SS, 431 Kyriakides ZS, 536 N L La Rovere MT, 422 La Vecchia C, 468 Lahiri A, S31 abs Nava A, 215 Lange PE, 89 Lange PE, 89 Langer I, 449 Lawford P, S6 Lawson-Matthew P, 146 Layton C, 7 Noble MIM, 341  Mishra M, S31 abs Nakagawa M, 87 Nakagawa M, 87 Lawford P, S6 Lawson-Matthew P, 146 Layton C, 7 Noble MIM, 341  Mishra M, S31 abs Mishra M, S31 abs Nakagawa M, S6 Layton C, 7 Noble MIM, 341  Mishra M, S31 abs Nakagawa M, S6 Saunders H, S36 abs Saunders H, S36 abs Saunders H, S36 abs			Ray SG, 395
Kiowski W, 449 Kiroivanou V, S34 abs Kisslo J, S28 Kitchiner D, 558, 588 Mixchell A, 408 Kitchiner D, 558, 588 Mixchell A, 408 Kitchiner D, 558, 588 Mixchell A, 408 Kitchiner D, 558, 588 Mixor M, 437 Kleine AH, 135 Molineaux N, 437 Knight C, 406 (E) Monaghan MJ, S1, S33 abs, S35 abs, 540 Koch L, 572 Mortara A, 422 Mortara A, 422 Mortara A, 422 Koster RW, 440 Moss J, 45 Kouchoukos NT, 404 (E) Mounsey IP, 202, 395 Kouchoukos NT, 404 (E) Mounsey IP, 202, 395 Kreidieh I, 334 Mukai J, 34 Kremastinos DT, 536 Mulcahy D, 406 (E) Kreidieh V, 242, 254 Mulligan IP, 268 Kübler W, 242, 254 Mulligan IP, 268 Kulakowski P, 521 Mureddu GF, 287 Kumar A, 79 Murray A, 386 Murray RG, 193 Kuray RG, 193 Kushwaha SS, 431 Kyriakides ZS, 536 N Nagata K, 34 Nakagawa M, 87 La Rovere MT, 422 Nakano O, 249 La Vecchia C, 468 Lahiri A, S31 abs Nava A, 215 Lange PE, 89 Langer I, 449 Lau FYK, 454 Lau FYK, 454 Lawford P, 86 Lawson-Matthew P, 146 Layson C, 7 Noble MIM, 341  Mishra M, S31 abs Nishoyannopoulos P, S1, S6, S15, S32 abs, S34 Saunders H, S36 abs Remppis A, 242 Reval K, 492 Rewal K, 492 Rewal K, 492 Rid, J, 515 Remppis A, 242 Reval K, 492 Rich, J, 515 Remppis A, 242 Reval K, 492 Rich, S1, 515 Remppis A, 242 Rich, J, 515 Remppis A, 242 Reval K, 492 Rich, S, 303 (L) Richardson M, 16 Richardson M, 16 Richardson M, 16 Richardson M, 30 Richards AM, 30 Richardson M, 146 R		• • •	Redington A, 479
Kirolivanou V, S34 abs Kisol J, S28 Mitchell A, 408 Kistchiner D, 558, 588 Kitchiner D, 558, 588 Kileine AH, 135 Knight C, 406 (E) Koch L, 572 Koster RW, 440 Koch L, 572 Koster RW, 440 Kouchoukos NT, 404 (E) Kreidieh I, 334 Kremastinos DT, 536 Kübler W, 242, 254 Kullakowski P, 521 Kumar A, 79 Kumar EB, 129 Kushawaha SS, 431 Kyriakides ZS, 536  L L Rovere MT, 422 La Rovere MT, 422 La Vecchia C, 468 Lahiri A, S31 abs Lange PE. 89 Langer I, 449 Lawford P, S6 Lawson-Matthew P, 146 Layton C, 7 Minday Miyao Y, 156 Moineaux N, 437 Roval K, 492 Rich S, 303 (L) Richardson M, 146 Richardson M, 146 Richardson M, 146 Richardson PJ, S33 abs Robotham KF, S34 abs Robotham KF, S36 abs Ro	• • •		Rees DHE, 459
Kisslo J, S28 Kitchiner D, 558, 588 Kitchiner D, 508, 538, 540 Konchotko E, Warter B, 521 Kreidieh I, 334 Kremastinos DT, 536 Kübler W, 242, 254 Kulakowski P, 521 Muray D, 406 (E) Kumar A, 79 Kumar EB, 129 Kushwaha SS, 431 Kyriakides ZS, 536 Nagata K, 34 La Rovere MT, 422 Nakano O, 249 La Vecchia C, 468 Lahiri A, S31 abs Nava A, 215 Nakano N, 55 Najata K, 34 Larovere MT, 424 Larovere MT, 425 La Vecchia C, 468 Lahiri A, S31 abs Nava A, 215 Nava A, 215 Nava A, 215 Nava A, 215 Saicad BT, 193 Saikawa T, 87 Sakamoto T, 156 Saltissi S, S15 Sanderson JE, 413, 490 (L) Santoro L, 468 Lawson-Matthew P, 146 Nobile AJ, 468 Layton C, 7 Noble MIM, 341	-	•	Reid J, 515
Kitchiner D, 558, 588 Kleine AH, 135 Kleine AH, 135 Knight C, 406 (E) Knoch L, 572 Koster RW, 440 Kouchoukos NT, 404 (E) Kreidieh I, 334 Kremastinos DT, 536 Kullakowski P, 521 Kumar A, 79 Kumar EB, 129 Kushwaha SS, 431 Kyriakides ZS, 536  L Rovere MT, 422 La Vecchia C, 468 Lahri A, S31 abs Lange PE, 89 Lange TI, 449 Lau FYK, 454 La Rover MT, 454 La Rover MT, 454 La Rover MT, 454 La Rover MT, 424 Lau FYK, 454 Lau FYK, 454 Lau FYK, 454 Lau FYK, 454 La Rover MT, 146 La Warner MT, 166 Layton C, 7 Noble MIM, 341 Mivao Y, 156 Molineaux N, 437 Rich S, 303 (L) Rich R, 30			Remppis A, 242
Kleine AH, 135			Reval K, 492
Knight C, 406 (E)  Koch L, 572  Mortara A, 422  Koster RW, 440  Kouchoukos NT, 404 (E)  Kreidieh I, 334  Kremastinos DT, 536  Kübler W, 242, 254  Kulakowski P, 521  Kumar A, 79  Kumar EB, 129  Kushwaha SS, 431  Kyriakides ZS, 536  L  L  L  L  L  L  L  R  Nagata K, 34  Nagata K, 34  Nagata K, 34  La Rovere MT, 422  La Vecchia C, 468  Lahiri A, S31 abs  Naya A, 215  Lange PE, 89  Lau FYK, 454  Lau FYK, 454  La Woon-Matthew P, 146  Layton C, 7  Monsghan MJ, S1, S33 abs, S35 abs, 540  Mortara A, 422  Richardson M, 146  Richardson PJ, 133 abs  Robotham KF, S34 abs  Roffe C, 141  Rosano GMC, 541  Rosano GMC, 541  Rosin MD, 193  Rosin M, 204  Rosin MD, 204  Rosin MD, 204  Rosi			
Koch L, 572         Mortara A, 422         Richardson M, 146           Koster RW, 440         Moss J, 45         Richardson PJ, S33 abs           Kouchoukos NT, 404 (E)         Mounsey JP, 202, 395         Robotham KF, S34 abs           Kouchoukos NT, 404 (E)         Mounsey JP, 202, 395         Robotham KF, S34 abs           Kreidieh I, 334         Mukai J, 34         Rosin GGC, 141           Kremastinos DT, 536         Mulcahy D, 406 (E)         Rosin MD, 193           Kübler W, 242, 254         Mulligan IP, 268         Ross I, 311           Kulakowski P, 521         Mureddu GF, 287         Rothman MT, 7           Kumar A, 79         Murray A, 386         Rosin, 193           Kumar BB, 129         Murray RG, 193         Rugarli C, 166           Kushwaha SS, 431         Rugarli C, 166           Kyriakides ZS, 536         N         Rugata K, 34           La Rovere MT, 422         Nakagawa M, 87           La Rovere MT, 422         Nakano O, 249         S           La Vecchia C, 468         Nathan AW, 96         Sadiq M, 566           Lahiri A, S31 abs         Nava A, 215         Saeed BT, 193           Langer I, 449         Niebauer J, 254         Sakamoto T, 156           Lau FYK, 454         Nihoyannopoulos P, S1, S6, S15, S32 abs, S34         Santoro L,			
Koster RW, 440 Kouchoukos NT, 404 (E) Kouchoukos NT, 404 (E) Kreidieh I, 334 Kremastinos DT, 536 Kübler W, 242, 254 Kulakowski P, 521 Mureddu GF, 287 Kumar A, 79 Murray A, 386 Kushwaha SS, 431 Kyriakides ZS, 536 N L La Rovere MT, 422 La Vecchia C, 468 Lahiri A, S31 abs Lange PE, 89 Langer I, 449 Lau FYK, 454 Lau FYK, 454 Lau FYK, 454 Lau Kyriakides P, 146 Layton C, 7 Mound Mounsey JP, 202, 395 Mounsey JP, 202, 395 Mounsey JP, 202, 395 Robotham KF, S34 abs Rosin MD, 193 Rosin MD, 194 Rosin MD, 1			•
Kouchoukos NT, 404 (E)         Mounsey JP, 202, 395         Robotham RF, 334 abs           Kreidieh I, 334         Mukai J, 34         Roffe C, 141           Kremastinos DT, 536         Mulcaly D, 406 (E)         Rosano GMC, 541           Kübler W, 242, 254         Mulligan IP, 268         Rosin MD, 193           Kulakowski P, 521         Murray RG, 287         Rothman MT, 7           Kumar A, 79         Murray A, 386         Rothman MT, 7           Kumar EB, 129         Murray RG, 193         Rouvier J, 151           Kushwaha SS, 431         Rugarli C, 166           Kyriakides ZS, 536         N         Rosand R, 34           L         Nagata K, 34         Ruttley MST, S35 abs           L         Nakano O, 249         S           La Vecchia C, 468         Nakano O, 249         S           Lange PE, 89         Neilson JM, 515         Saiday M, 566           Langer I, 449         Niebauer J, 254         Saikawa T, 87           Lau FYK, 454         Nihoyannopoulos P, S1, S6, S15, S32 abs, S34         Saltissi S, S15           Lawford P, S6         abs, 224         Sanderson JE, 413, 490 (L)           Lawson-Matthew P, 146         Nobil A, 468         Saunders H, S36 abs	The state of the s		Richardson PJ, S33 abs
Kreidieh I, 334       Mukai J, 34       Rofte C, 141         Kremastinos DT, 536       Mulcahy D, 406 (E)       Rosano GMC, 541         Kübler W, 242, 254       Mulligan IP, 268       Ross I, 311         Kulakowski P, 521       Mureddu GF, 287       Rothman MT, 7         Kumar A, 79       Murray A, 386       Rouvier J, 151         Kushwaha SS, 431       Rujz CE, 454         Kyriakides ZS, 536       N       Ruiz CE, 454         L       Nakagawa M, 87         La Rovere MT, 422       Nakano O, 249       S         La Vecchia C, 468       Nathan AW, 96       Sadiq M, 566         Lahiri A, S31 abs       Nava A, 215       Saeed BT, 193         Lange PE, 89       Neilson JM, 515       Saikawa T, 87         Langer I, 449       Niebauer J, 254       Sakamoto T, 156         Lawford P, S6       abs, 224       Saltissi S, S15         Lawford P, S6       abs, 224       Sanderson JE, 413, 490 (L)         Lawson-Matthew P, 146       Nobili A, 468       Saunders H, S36 abs			
Kremastinos DT, 536       Mulcahy D, 406 (E)       Rosan GMC, 341         Kübler W, 242, 254       Mulligan IP, 268       Rosin MD, 193         Kulakowski P, 521       Mureddu GF, 287       Rothman MT, 7         Kumar A, 79       Murray A, 386       Rothman MT, 7         Kumar EB, 129       Murray RG, 193       Rugarli C, 166         Kushwaha SS, 431       Rugarli C, 166         Kyriakides ZS, 536       N       Ruttley MST, S35 abs         L       Nakagawa M, 87         La Rovere MT, 422       Nakano O, 249       S         La Vecchia C, 468       Nathan AW, 96       Sadiq M, 566         Lahiri A, S31 abs       Nava A, 215       Saeed BT, 193         Lange PE, 89       Neilson JM, 515       Saikawa T, 87         Langer I, 449       Niebauer J, 254       Saltissi S, S15         Lawford P, S6       abs, 224       Sanderson JE, 413, 490 (L)         Lawson-Matthew P, 146       Nobili A, 468       Saunders H, S36 abs         Layton C, 7       Noble MIM, 341       Saunders H, S36 abs			Roffe C, 141
Kübler W, 242, 254       Mulligan IP, 268       Rosin MD, 195         Kulakowski P, 521       Mureddu GF, 287       Rost I, 311         Kumar A, 79       Murray A, 386       Rothman MT, 7         Kumar EB, 129       Murray RG, 193       Rugarli C, 166         Kushwaha SS, 431       Rugarli C, 166         Kyriakides ZS, 536       N       Ruiz CE, 454         L       Nakagawa M, 87       Ruttley MST, S35 abs         L       Nakagawa M, 87       S         La Rovere MT, 422       Nakano O, 249       S         La Vecchia C, 468       Nathan AW, 96       Sadiq M, 566         Lahiri A, S31 abs       Nava A, 215       Saeed BT, 193         Lange PE, 89       Neilson JM, 515       Saikawa T, 87         Lau FYK, 454       Niebauer J, 254       Sakamoto T, 156         Law FYK, 454       Nihoyannopoulos P, S1, S6, S15, S32 abs, S34       Saltissi S, S15         Lawson-Matthew P, 146       Nobili A, 468       Santoro L, 468         Layton C, 7       Noble MIM, 341       Saunders H, S36 abs	The state of the s		Rosano GMC, 541
Kulakowski P, 521       Mureddu GF, 287       Ross 1, 311         Kumar A, 79       Murray A, 386       Rothman MT, 7         Kumar EB, 129       Murray RG, 193       Rugarli C, 166         Kushwaha SS, 431       Rugarli C, 166         Kyriakides ZS, 536       N       Ruiz CE, 454         L       Nakagawa M, 87       Ruttley MST, S35 abs         La Rovere MT, 422       Nakano O, 249       S         La Vecchia C, 468       Nathan AW, 96       Sadiq M, 566         Lahiri A, S31 abs       Nava A, 215       Saeed BT, 193         Lange PE, 89       Neilson JM, 515       Saikawa T, 87         Lau FYK, 454       Nihoyannopoulos P, S1, S6, S15, S32 abs, S34       Saltissi S, S15         Lawford P, S6       abs, 224       Sanderson JE, 413, 490 (L)         Lawson-Matthew P, 146       Nobili A, 468       Saunders H, S36 abs         Layton C, 7       Noble MIM, 341       Saunders H, S36 abs		• • •	Rosin MD, 193
Kumar A, 79       Murray A, 386       Rotinan M1, 7         Kumar EB, 129       Murray RG, 193       Rouvier J, 151         Kushwaha SS, 431       Rugarli C, 166         Kyriakides ZS, 536       N       Ruttley MST, S35 abs         L       Nakagawa M, 87         La Rovere MT, 422       Nakano O, 249       S         La Vecchia C, 468       Nathan AW, 96       Sadiq M, 566         Lahiri A, S31 abs       Nava A, 215       Saeed BT, 193         Lange PE, 89       Neilson JM, 515       Saikawa T, 87         Langer I, 449       Niebauer J, 254       Sakamoto T, 156         Lau FYK, 454       Nihoyannopoulos P, S1, S6, S15, S32 abs, S34       Saltissi S, S15         Lawford P, S6       abs, 224       Sanderson JE, 413, 490 (L)         Lawson-Matthew P, 146       Nobili A, 468       Saunders H, S36 abs         Layton C, 7       Noble MIM, 341       Saunders H, S36 abs			Ross I, 311
Kumar EB, 129       Murray RG, 193       Rouvier J, 151         Kushwaha SS, 431       Rugarli C, 166         Kyriakides ZS, 536       N       Rugarli C, 166         Nagata K, 34       Ruttley MST, S35 abs         L       Nakagawa M, 87         La Rovere MT, 422       Nakano O, 249       S         La Vecchia C, 468       Nathan AW, 96       Sadiq M, 566         Lahiri A, S31 abs       Nava A, 215       Saeed BT, 193         Lange PE, 89       Neilson JM, 515       Saikawa T, 87         Langer I, 449       Niebauer J, 254       Sakamoto T, 156         Law FYK, 454       Nihoyannopoulos P, S1, S6, S15, S32 abs, S34       Saltissi S, S15         Lawford P, S6       abs, 224       Sanderson JE, 413, 490 (L)         Lawson-Matthew P, 146       Nobili A, 468       Saunders H, S36 abs         Layton C, 7       Noble MIM, 341       Saunders H, S36 abs			Rothman MT, 7
Kushwaha SS, 431       Rugarn C, 160         Kyriakides ZS, 536       N       Ruiz CE, 454         L       Nagata K, 34       Ruttley MST, S35 abs         L       Nakagawa M, 87       S         La Rovere MT, 422       Nakano O, 249       S         La Vecchia C, 468       Nathan AW, 96       Sadiq M, 566         Lahiri A, S31 abs       Nava A, 215       Saeed BT, 193         Lange PE, 89       Neilson JM, 515       Saikawa T, 87         Langer I, 449       Niebauer J, 254       Sakamoto T, 156         Lau FYK, 454       Nihoyannopoulos P, S1, S6, S15, S32 abs, S34       Saltissi S, S15         Lawford P, S6       abs, 224       Sanderson JE, 413, 490 (L)         Lawson-Matthew P, 146       Nobili A, 468       Santoro L, 468         Layton C, 7       Noble MIM, 341       Saunders H, S36 abs			Rouvier J, 151
Kuiz CE, 434   Ruttley MST, S35 abs		Muliay RG, 193	Rugarli C, 166
Nagata K, 34  L Nakagawa M, 87  La Rovere MT, 422 Nakano O, 249 S  La Vecchia C, 468 Nathan AW, 96 Sadiq M, 566  Lahiri A, S31 abs Nava A, 215 Saeed BT, 193  Lange PE, 89 Neilson JM, 515 Saikawa T, 87  Langer I, 449 Niebauer J, 254 Sakamoto T, 156  Lau FYK, 454 Nihoyannopoulos P, S1, S6, S15, S32 abs, S34  Lawford P, S6 abs, 224 Sanderson JE, 413, 490 (L)  Lawson-Matthew P, 146 Nobili A, 468 Santoro L, 468  Layton C, 7 Noble MIM, 341 Saunders H, S36 abs		N	•
L       Nakagawa M, 87         La Rovere MT, 422       Nakano O, 249       S         La Vecchia C, 468       Nathan AW, 96       Sadiq M, 566         Lahiri A, S31 abs       Nava A, 215       Saeed BT, 193         Lange PE, 89       Neilson JM, 515       Saikawa T, 87         Lauger I, 449       Niebauer J, 254       Sakamoto T, 156         Lau FYK, 454       Nihoyannopoulos P, S1, S6, S15, S32 abs, S34       Saltissi S, S15         Lawford P, S6       abs, 224       Sanderson JE, 413, 490 (L)         Lawson-Matthew P, 146       Nobili A, 468       Santoro L, 468         Layton C, 7       Noble MIM, 341       Saunders H, S36 abs	Tyrianuco 20, 700		Ruttley MST, S35 abs
La Rovere MT, 422       Nakano O, 249       S         La Vecchia C, 468       Nathan AW, 96       Sadiq M, 566         Lahiri A, S31 abs       Nava A, 215       Saeed BT, 193         Lange PE, 89       Neilson JM, 515       Saikawa T, 87         Langer I, 449       Niebauer J, 254       Sakamoto T, 156         Lau FYK, 454       Nihoyannopoulos P, S1, S6, S15, S32 abs, S34       Saltissi S, S15         Lawford P, S6       abs, 224       Sanderson JE, 413, 490 (L)         Lawson-Matthew P, 146       Nobili A, 468       Santoro L, 468         Layton C, 7       Noble MIM, 341       Saunders H, S36 abs	ī	<b>o</b> ,	
La Vecchia C, 468  Lahiri A, S31 abs  Lange PE, 89  Langer I, 449  Langer I, 449  Lau FYK, 454  Lawford P, S6  Lawford P, S6  Lawton C, 7  Noble MIM, 341  Nathan AW, 96  Sadiq M, 566  Saeed BT, 193  Saikawa T, 87  Sakamoto T, 156  Saltissi S, S15  Sanderson JE, 413, 490 (L)  Santoro L, 468  Saunders H, S36 abs		•	S
Lahiri A, S31 abs       Nava A, 215       Saeed BT, 193         Lange PE, 89       Neilson JM, 515       Saikawa T, 87         Langer I, 449       Niebauer J, 254       Sakamoto T, 156         Lau FYK, 454       Nihoyannopoulos P, S1, S6, S15, S32 abs, S34       Saltissi S, S15         Lawford P, S6       abs, 224       Sanderson JE, 413, 490 (L)         Lawson-Matthew P, 146       Nobili A, 468       Santoro L, 468         Layton C, 7       Noble MIM, 341       Saunders H, S36 abs			
Lange PE, 89 Neilson JM, 515 Saikawa T, 87  Langer I, 449 Niebauer J, 254 Sakamoto T, 156  Lau FYK, 454 Nihoyannopoulos P, S1, S6, S15, S32 abs, S34 Saltissi S, S15  Lawford P, S6 abs, 224 Sanderson JE, 413, 490 (L)  Lawson-Matthew P, 146 Nobili A, 468 Saunders H, S36 abs  Layton C, 7 Noble MIM, 341 Saunders H, S36 abs			
Langer I, 449 Lau FYK, 454 Lawford P, S6 Lawson-Matthew P, 146 Layton C, 7  Niebauer J, 254 Nihoyannopoulos P, S1, S6, S15, S32 abs, S34 Sakamoto T, 156 Saltissi S, S15 Sanderson JE, 413, 490 (L) Santoro L, 468 Saunders H, S36 abs			The state of the s
Lau FYK, 454  Lau FYK, 454  Nihoyannopoulos P, S1, S6, S15, S32 abs, S34  Lawford P, S6  Lawson-Matthew P, 146  Layton C, 7  Noble MIM, 341  Saltissi S, S15  Sanderson JE, 413, 490 (L)  Santoro L, 468  Saunders H, S36 abs	•		
Lawford P, S6       abs, 224       Sanderson JE, 413, 490 (L)         Lawson-Matthew P, 146       Nobili A, 468       Santoro L, 468         Layton C, 7       Noble MIM, 341       Saunders H, S36 abs			
Lawson-Matthew P, 146 Nobili A, 468 Santoro L, 468 Layton C, 7 Noble MIM, 341 Saunders H, S36 abs			
Layton C, 7 Noble MIM, 341 Saunders H, S36 abs			
Eayton C, 1			
		_ ·	

602 Author Index

Scalfi L, 287	Sutton MStJ, 115 (R), 232	W
Scalia G, 554	Sutton R, 191, 274	Waagstein F, 261
Scazziota A, 151	Swan JW, 41	Wainwright RJ, S31 abs
Scheffold T, 242	Sweetnam PM, 293	Walesby R, 177
Schömig A, 254	Syndercombe Court YD, 7	Wallbridge DR, 446: correction, 597
Schuler G, 254		Walsh K, 588
Schulze-Neick I, 89	T	Walton C, 41
Schwarz F, 254	Taggart DP, 177	Walton S, 311
Senior R, S31 abs	Takeshita A, 181	Ward C, 82, 219 (R)
Shah D, 224	Tammaro P, 287	Ward D, 521
Shahrabani R, 29	Tavazzi L, 422	Ward DE, 119 (R), 554
Shakespeare CF, 22	Teale JD, 293	Webb DW, 490 (L)
Shapiro LM, 57, S35 abs	Tean KN, 92	Webb-Peploe M, 492
Sharkey AM, 370	Thiene G, 215	Webb-Peploe MM, 22
Sharland G, 232	Thomas J, 334	West RR, 382
Sharland GK, 70	Thomas MR, S33 abs, S35 abs, 378	Why H, 540
Shaw TRD, 297	Thomas R, 490 (L)	Why HJF, S33 abs
Sheldon S, 76	Thomas S, 378	Wielogorski AK, 349
Shimizu W, 34	Thorne SA, 489	Wilkinson P, 329
Shimoda T, 182	Tillmanns H, 254	Williams CA, 79
Shinebourne EA, 579	Timmins J, 7	Williams D, 558
Shirlaw TM, 30	Timmis AD, 7, 309 (V), 329	Williams T, 274
Shore D, 579	Todesco P, 468	Wilmshurst PT, 209 (E), 229
Signorini MG, 422	Toosy T, 437	Winberg P, 282
Sigwart U, 372	Tranchesi B, 249	Wisbey CR, 57
Simpson I, S6	Travill C, 341	Woods KL, 141
Smith SE, 229	Treacher DF, 229	Wren C, S20, 102
Smyth DW, 378	Tresoldi M, 166	Wright JE, 177
Sneddon J, 16	Triggiani M, 109 (L)	Wyllie J, S20
Sneddon JF, 554	Tsuchioka Y, 34	y <b>3</b> ,
Somerville J, 479	Turkie WH, 316	X
**	Tynan M, 492	Xia R, 521
Song GJ, 341	1 y 11 a 1 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1	Xiao HB, 548
Sparrow J, 391	U	Xu M, 51
Spriggins D, 7	Underwood R, 490 (L), 541	•
Srámek M, 440	Urabe Y, 181	Y
Sreeram N, 558	01400 1, 101	Yacoub M, 408, 579
Staal MJ, 413	V	Yacoub MH, 431
Stables R, 406 (E)	Vaishnav S, 329	Yamada A, 181
Statters DJ, 16, 322	Valliathu J, 29	Yamagata T, 34
Staunton A, 521	van der Vusse GJ, 135	Yapanis A, S36 abs
Stevenson JC, 41	van Dieijen-Visser MP, 135	Yapanis AG, S31 abs
Stevenson R, 329		Yarnell JWG, 293
Stockley RA, 303 (L)	van Hemel NM, 170	
Stockman S, 531	van Nieuwenhoven FA, 135	Yashira K, 182
Strachan D, 437	Venning MC, 82	Yasue H, 156
Straumann E, 449	Ventura G, 468	Young V, 177
Steel SA, 129	Venugopalan P, 358	Yu Q, 156
Stulz P, 449	Vermeulen FEE, 170	7
Stumper O, 63	Victorica BE, 79	Z
Sutherland GR, S32 abs	Vidal M, 166	Zehelein J, 242
Sutton MGStJ, 187	Vogel M, 462	Zhang HP, 454

# **VOLUME 71: SUBJECT INDEX**

S = British Society of Echocardiography Supplement 1994

Α

Ablation, Radiofrequency catheter ablation: a new frontier in interventional cardiology: review, 119

Acronyms, Acronym aggravation: letter, 107

Adenosine, Haemodynamic deterioration after treatment with adenosine, 569

Allopurinol, Lack of cardioprotective efficacy of allopurinol in coronary artery surgery, 177

Amoebiasis, Amoebiasis: a rare cause of cardiac tamponade, 368

Anaemia, Pathogenesis of oedema in chronic severe anaemia: letter, 490

An accidental aneurysm: an incidental finding: images in cardiology, 489 False aneurysm of the right ventricular outflow tract after total correction of tetralogy of Fallot: diagnosis by echocardiography and successful repair by neck cannulation for cardiopulmonary bypass, 566 Transcatheter closure of a ruptured aneurysm of the sinus of Valsalva, 479

Angina

Angiotensin converting enzyme inhibition in chronic stable angina: effects on myocardial ischaemia and comparison with nifedipine, 30 Circadian variation in fibrinolytic activity in patients with variant angina, 156

Does pain relief with spinal cord stimulation for angina conceal myocardial infarction?, 419

Implication of prescriptions for nitrates: 7 year follow up of patients treated for angina in general practice, 38

Importance of thrombosis and thrombolysis in silent ischaemia: comparison of patients with acute myocardial infarction and unstable angina, 151

Influence of the autonomic nervous system on circadian patterns of myocardial ischaemia: comparison of stable angina with the early postinfarction period, 329

Lasers, burns, cuts, tingles and pumps: a consideration of alternative treatments for intractable angina: editorial, 406

Angiotensin converting enzyme inhibition

Angiotensin converting enzyme inhibition in chronic stable angina: effects on myocardial ischaemia and comparison with nifedipine, 30 Should angiotensin converting enzyme (ACE) inhibitors be used routinely after infarction? Perspectives from the Survival and Ventricular Enlargement (SAVE) Trial: review, 115

Anorexia nervosa, Cardiac abnormalities in young women with anorexia nervosa, 287

Anterior staircase manoeuvre, Anterior staircase manoeuvre for atrial transseptal puncture, 297

Aortic Doppler velocimetry, Exercise electrocardiography and aortic Doppler velocimetry in asymptomatic identical twins discordant for type 1 (insulin dependent) diabetes, 341

Aortic stenosis

Aortic valve replacement in elderly patients with aortic stenosis, 449
Diastolic function in aortic stenosis versus systemic hypertension: a
Doppler echocardiographic study, \$34 abs

Doppler echocardiographic assessment of early changes in diastolic function after aortic valve replacement for aortic stenosis, \$34 abs

Profiles of coronary blood flow velocity in patients with aortic stenosis and the effect of valve replacement: a transthoracic echocardiographic study, 57

Aortic valve

Aortic valve replacement in elderly patients with aortic stenosis, 449
Balloon dilatation of the aortic valve after previous surgical valvotomy: immediate and follow up results, 558

Aortography, End-on aortogram: improved identification of important coronary artery anomalies in tetralogy of Fallot, 102

Aortopulmonary collaterals, Stenting of stenosed aortopulmonary collaterals: a new approach to palliation in pulmonary atresia with multifocal aortopulmonary blood supply, 487

Appetite depressants, International Primary Pulmonary Hypertension Study: letter, 303

Aprotinin, Randomised placebo controlled double blind study of two low dose aprotinin regimens in cardiac surgery, 349

Arrhythmias, Investigation of the effects of intravenous magnesium sulphate on cardiac rhythm in acute myocardial infarction, 141

Arrhythmogenic right ventricular dysplasia

Arrhythmogenic right ventricular dysplasia, 214

Diagnosis of arrhythmogenic right ventricular dysplasia/cardiomyopathy, 215

Arterial saturation, Effects of a patent foramen ovale on arterial saturation during exercise and on cardiovascular responses to deep breathing, Valsalva manoeuvre, and passive tilt: relation to history of decompression illness in divers, 229

Artificial heart valves, Echocardiographic assessment of artificial heart valves: British Society of Echocardiography position paper, \$6

Aspirin, Is this the end of the aspirin and vein graft story? commentary, 510

#### Atrial fibrillation

Haemodynamic deterioration after treatment with adenosine, 569 Long-term results of the corridor operation for atrial fibrillation, 170 Surgery for atrial fibrillation: *editorial*, 501

Treatment of atrial fibrillation in a district general hospital, 92

Atrial myxoma, Value of multiplane transoesophageal echocardiography in recurrent atrial myxoma, 540

Atrial transseptal puncture, Anterior staircase manoeuvre for atrial transseptal puncture, 297

Atrioventricular septal defect

Complete atrioventricular septal defect with tetralogy of Fallot: diagnosis and management, 579

Familial atrioventricular septal defect: possible genetic mechanisms, 79

Atropine, Differential effect of pharmacological autonomic blockade on some electrophysiological properties of the human ventricle and atrium, 34

Audit, Impact of internal audit on pacemaker prescription and the immediate costs of pacing in the Northern Region: towards implementation of the recommendations of the British Pacing and Electrophysiology Group, 395

Autonomic blockade, Differential effect of pharmacological autonomic blockade on some electrophysiological properties of the human ventricle and atrium, 34

Autonomic nerve function, Differences in autonomic nerve function in patients with silent and symptomatic myocardial ischaemia, 22

В

**Bail-out device**, Temporary stent as a bail-out device during percutaneous transluminal coronary angioplasty: preliminary clinical experience, 372

Balloon dilatation, Balloon dilatation of the aortic valve after previous surgical valvotomy: immediate and follow up results, 558

Balloon venoplasty, Successful treatment by balloon venoplasty and stent insertion of obstruction of the superior vena cava by an endocardial pacemaker lead. 363

Basal lamina, Is thickening of the basal lamina in the saphenous vein a hallmark of smoking?, 45

Benazepril, Angiotensin converting enzyme inhibition in chronic stable angina: effects on myocardial ischaemia and comparison with nifedipine, 30

Bendrofluazide, Combination diuretic treatment in severe heart failure, 146

Beta blockade, Effect of beta blockade on the neurohumoral and cardiopulmonary response to dynamic exercise in cardiac transplant recipients, 431

Bland-White-Garland syndrome, Successful operation in an old survivor of anomalous origin of the left coronary artery from the pulmonary trunk (Bland-White-Garland syndrome), 193

Blood flov

Assessment of changes in blood flow through the lungs and foramen ovale in the normal human fetus with gestational age: a prospective Doppler echocardiographic study, 232

Profiles of coronary blood flow velocity in patients with aortic stenosis and the effect of valve replacement: a transthoracic echocardiographic study, 57

Borrelia burgdorferi, No evidence to implicate Borrelia burgdorferi in the pathogenesis of dilated cardiomyopathy in the United Kingdom, 459

**British Cardiac Society** 

Mobile cardiac catheterisation laboratory: recommendations of the Medical Practice Committee and Council of the British Cardiac Society, 207

Newsletters, 109, 206, 304, 399, 490, 596

Strategic planning for cardiac services and the internal market: role of catheterisation laboratories in district general hospitals: BCS Council statement, 110

С

Caerphilly prospective study, Insulin in ischaemic heart disease: are associations explained by triglyceride concentrations? The Caerphilly prospective study, 293

Cardiac efficiency, Short-term effects of right atrial, right ventricular apical, and atrioventricular sequential pacing on myocardial oxygen consumption and cardiac efficiency in patients with coronary artery disease, 536

Cardiac surgery

artinac surgery
How transoesophageal echocardiography can assist cardiac surgery in adults: editorial, 404

Randomised placebo controlled double blind study of two low dose aprotinin regimens in cardiac surgery, 349

Cardiac tamponade, Amoebiasis: a rare cause of cardiac tamponade, 368

Cardioinhibitory malignant vasovagal syndrome, Permanent pacing for cardioinhibitory malignant vasovagal syndrome, 274

Cardiomyoplasty, Colour Doppler imaging of skeletal muscle and myocardium after dynamic cardiomyoplasty, S32 abs

Cardioprotection, Lack of cardioprotective efficacy of allopurinol in coronary artery surgery, 177

Cardiovascular pathology, Cardiovascular pathology in Europe: a new school, 507

Cardiovascular responses, Effects of a patent foramen ovale on arterial saturation during exercise and on cardiovascular responses to deep breathing, Valsalva manoeuvre, and passive tilt: relation to history of decompression illness in divers, 229

Cardioverter defibrillator, Use of an implantable cardioverter defibrillator in a patient with a rate responsive pacemaker, 191

Catheter ablation, Radiofrequency catheter ablation: a new frontier in interventional cardiology: review, 119

#### Catheterisation

Mobile cardiac catheterisation laboratory: recommendations of the Medical Practice Committee and Council of the British Cardiac Society, 207

Strategic planning for cardiac services and the internal market: role of catheterisation laboratories in district general hospitals: BCS Council statement, 110

Validation of dobutamine stress digital echocardiography during cardiac catheterisation, S31 abs

## Cholesterol

Can any agreement be reached on cholesterol lowering?, 125

Serum cholesterol and acute myocardial infarction: a case-control study from the GISSI-2 trial, 468

Circadian patterns, Influence of the autonomic nervous system on circadian patterns of myocardial ischaemia: comparison of stable angina with the early postinfarction period, 329

#### Coarctation of the aorta

Coarctation of the aorta: difficulties in prenatal diagnosis, 70

Mitral valve hypoplasia in children with isolated coarctation of the aorta, 358

Colour Doppler imaging, Colour Doppler imaging of skeletal muscle and myocardium after dynamic cardiomyoplasty, S32 abs

Conduction disturbance, Relative effects of left ventricular mass and conduction disturbance on activation in patients with pathological left ventricular hypertrophy, 548

Congenital heart defects, Dynamic three-dimensional echocardiography with a computed tomography imaging probe: initial clinical experience with transthoracic application in infants and children with congenital heart defects, 462

## Congenital heart disease

Effect of inhaled nitric oxide on raised pulmonary vascular resistance in children with congenital heart disease, 282

Screening for fetal cardiac malformations, \$20

Conotruncal and aorto-pulmonary septum, Maldevelopment of conotruncal and aorto-pulmonary septum with absent left central pulmonary artery: anatomical and clinical implications, 89

# Coronary angiography

Exercise testing without interruption of medication for refining the selection of mildly symptomatic patients for prognostic coronary angiography, 334

Variations in the use of coronary angiography in three cities in the Trent Region, 474

# Coronary artery

Intravascular ultrasound imaging of angiographically normal coronary arteries: a prospective study in vivo, 572

Lack of cardioprotective efficacy of allopurinol in coronary artery surgery, 177

# Coronary artery bypass surgery (grafting)

Coronary artery bypass surgery: current practice in the United Kingdom, 382

Coronary artery surgery in women compared with men: analysis of coronary risk factors and in-hospital mortality in a single centre, 408 Is this the end of the aspirin and vein graft story? commentary, 510

# Coronary artery disease

Cardiac parasympathetic activity in severe uncomplicated coronary artery disease, 515

Effects of spinal cord stimulation on myocardial ischaemia during daily life in patients with severe coronary artery disease, 413

Short-term effects of right atrial, right ventricular apical, and atrioventricular sequential pacing on myocardial oxygen consumption and cardiac efficiency in patients with coronary artery disease, 536

Coronary blood flow, Profiles of coronary blood flow velocity in patients with aortic stenosis and the effect of valve replacement: a transthoracic echocardiographic study, 57

# Coronary heart disease

Coronary heart disease, the menopause, and hormone replacement therapy, 213

Relation of *Helicobacter pylori* infection and coronary heart disease, 437 The rights of women: *editorial*, 401

Coronary stenoses, Long-term function in the remote region after

myocardial infarction: importance of significant coronary stenoses in the non-infarct-related artery, 249

#### **Correction**, 207, 208

Corridor operation, Long-term results of the corridor operation for atrial fibrillation, 170

Cough, Mechanism of pacemaker induced cough, 484

Creatine kinase, Comparison of the value of novel rapid measurement of myoglobin, creatine kinase, and creatine kinase-MB with the electrocardiogram for the diagnosis of acute myocardial infarction, 311

Creatine kinase-MB, Comparison of the value of novel rapid measurement of myoglobin, creatine kinase, and creatine kinase-MB with the electrocardiogram for the diagnosis of acute myocardial infarction, 311

Cyanosis, Transcatheter coil embolisation of a pulmonary arteriovenous malformation in a neonate, 370

D

Diabetes, Exercise electrocardiography and aortic Doppler velocimetry in asymptomatic identical twins discordant for type 1 (insulin dependent) diabetes, 341

## Dilated cardiomyopathy

Do specific HLA antigens predispose to ischaemic heart disease or idiopathic dilated cardiomyopathy?, 76

No evidence to implicate Borrelia burgdorferi in the pathogenesis of dilated cardiomyopathy in the United Kingdom, 459

**Dipyridamole**, Dipyridamole is superior to dobutamine for thallium stress imaging, 129

Direct access exercise electrocardiography, Direct access exercise electrocardiography: a new service that improves the management of suspected ischaemic heart disease in the community, 531

Diuretics, Combination diuretic treatment in severe heart failure, 146
Dobutamine

Dipyridamole is superior to dobutamine for thallium stress imaging, 129 Haemodynamic changes during dobutamine stress echocardiography: implications for the detection of viable myocardium, S31 abs

Myocardial ischaemia during dobutamine stress echocardiography induces 'dynamic' mitral regurgitation, S31 abs

Validation of dobutamine stress digital echocardiography during cardiac catheterisation, S31 abs

## Doppler

Diastolic function in aortic stenosis versus systemic hypertension: a Doppler echocardiographic study, **S34** abs

Doppler echocardiographic assessment of early changes in diastolic function after aortic valve replacement for aortic stenosis, \$34 abs

Measurement of isovolumic relaxation time by Doppler and dual M-mode techniques: comparison and pitfalls, \$33 abs

Ductus arteriosus, Medium-term follow up of residual shunting and potential complications after transcatheter occlusion of the ductus arteriosus, 63

Ε

## Echocardiography

Assessment of changes in blood flow through the lungs and foramen ovale in the normal human fetus with gestational age: a prospective Doppler echocardiographic study, 232

Assessment of ejection fraction by echocardiographic automatic boundary detection following myocardial infarction: comparison with radionuclide angiography, \$33 abs

Diastolic function in aortic stenosis versus systemic hypertension: a Doppler echocardiographic study, \$34 abs

Doppler echocardiographic assessment of early changes in diastolic function after aortic valve replacement for aortic stenosis, **S34** abs

Dynamic three-dimensional echocardiography with a computed tomography imaging probe: initial clinical experience with transthoracic application in infants and children with congenital heart defects, 462

Echocardiographic assessment of artificial heart valves: British Society of Echocardiography position paper,  ${\bf S6}$ 

Echocardiographic assessment of the mitral valve does not predict clinically useful balloon dilatation, S36 abs

Echocardiography: foreword to British Society of Echocardiography supplement 1994, S1

Haemodynamic changes during dobutamine stress echocardiography: implications for the detection of viable myocardium, S31 abs

Myocardial ischaemia during dobutamine stress echocardiography induces 'dynamic' mitral regurgitation, S31 abs

On-line echocardiographic automatic boundary detection assessment of left ventricular cardiac contractility, \$33 abs

Screening for fetal cardiac malformations, \$20

To my friend in echocardiography: letter from America, S28

Training in echocardiography, S2

Two-dimensional echo-guided invasive cardiological procedures in the district general hospital, \$33 abs

Validation of dobutamine stress digital echocardiography during cardiac catheterisation, S31 abs

Effective refractory period, Differential effect of pharmacological

autonomic blockade on some electrophysiological properties of the human ventricle and atrium, 34

Ejection fraction, Assessment of ejection fraction by echocardiographic automatic boundary detection following myocardial infarction: comparison with radionuclide angiography, \$33 abs

#### Electrocardiography

Comparison of the value of novel rapid measurement of myoglobin, creatine kinase, and creatine kinase-MB with the electrocardiogram for the diagnosis of acute myocardial infarction, 311

Direct access exercise electrocardiography: a new service that improves the management of suspected ischaemic heart disease in the community, 531

Muscular false tendons, aberrant left ventricular papillary musculature, and severe electrocardiographic repolarisation abnormalities: a new syndrome, 187

Relations between resting ventricular long axis function, the electrocardiogram, and myocardial perfusion imaging in syndrome X, 541

Emergency calls, Telephone triage of cardiac emergency calls by dispatchers: a prospective study of 1386 emergency calls, 440

End-on aortogram, End-on aortogram: improved identification of important coronary artery anomalies in tetralogy of Fallot, 102

Endorphins, Increase in plasma beta endorphins precedes vasodepressor syncope, 446: correction, 597

#### Endothelium

Does X equal endothelial dysfunction? abstracts in cardiology, 181
Evidence of impaired endothelium-dependent coronary vasodilatation
in patients with angina pectoris and normal coronary angiograms:
abstracts in cardiology, 181

#### Enzymes

Comparison of the value of novel rapid measurement of myoglobin, creatine kinase, and creatine kinase-MB with the electrocardiogram for the diagnosis of acute myocardial infarction, 311

Will serum enzymes and other proteins find a clinical application in the early diagnosis of myocardial infarction? viewpoint, 309

**Epoprostenol**, Failure of epoprostenol (prostacyclin, PGI2) to inhibit platelet aggregation and to prevent restenosis after coronary angioplasty, 7

Erosion, pacemaker, Mechanical, but not infective, pacemaker erosion may be successfully managed by re-implantation of pacemakers, 202

European School for Cardiovascular Pathology, Cardiovascular pathology in Europe: a new school, 507

#### Exercise

Assessment of functional capacity in chronic heart failure: timelimited exercise on a self-powered treadmill, 391

Direct access exercise electrocardiography: a new service that improves the management of suspected ischaemic heart disease in the community, 531

Effect of beta blockade on the neurohumoral and cardiopulmonary response to dynamic exercise in cardiac transplant recipients, 431

Effects of motivation of the patient on indices of exercise capacity in chronic heart failure, 162

Exercise electrocardiography and aortic Doppler velocimetry in asymptomatic identical twins discordant for type 1 (insulin dependent) diabetes, 341

Exercise induced vasodepressor syncope, 554

Exercise testing without interruption of medication for refining the selection of mildly symptomatic patients for prognostic coronary angiography, 334

Transmitral flow pattern during short exercise: a predictor of ventricular contractile reserve following myocardial infarction, S32 abs

Usefulness of arterial blood gas estimations during exercise in patients with chronic heart failure, 528

F

False aneurysm, False aneurysm of the right ventricular outflow tract after total correction of tetralogy of Fallot: diagnosis by echocardiography and successful repair by neck cannulation for cardiopulmonary bypass, 566

Fatty-acid-binding protein, Fatty-acid-binding protein as a plasma marker for the estimation of myocardial infarct size in humans, 135 Fenfluramine, International Primary Pulmonary Hypertension Study:

letter, 303
Fetal echocardiography, Screening for fetal cardiac malformations, \$20
Fibrinolytic activity, Circadian variation in fibrinolytic activity in patients with variant angina, 156

Foramen ovale, Assessment of changes in blood flow through the lungs and foramen ovale in the normal human fetus with gestational age: a prospective Doppler echocardiographic study, 232

G

Gas estimations, Usefulness of arterial blood gas estimations during exercise in patients with chronic heart failure, 528

н

#### Heart failure

Assessment of functional capacity in chronic heart failure: time-

limited exercise on a self-powered treadmill, 391

Can power spectral analysis of heart rate variability identify a high risk subgroup of congestive heart failure patients with excessive sympathetic activation? A pilot study before and after heart transplantation, 422

Cardiac neuropeptide Y and noradrenaline balance in patients with congestive heart failure, 261

Combination diuretic treatment in severe heart failure: a randomised controlled trial, 146

Effects of motivation of the patient on indices of exercise capacity in chronic heart failure, 162

Evidence of inadequate investigation and treatment of patients with heart failure, 584

Heart rate variability and its relation to ventricular arrhythmias in congestive heart failure, 322

QT interval dispersion in chronic heart failure and left ventricular hypertrophy: relation to autonomic nervous system and Holter tape abnormalities, 268

Usefulness of arterial blood gas estimations during exercise in patients with chronic heart failure, 528

#### Heart ra

Can power spectral analysis of heart rate variability identify a high risk subgroup of congestive heart failure patients with excessive sympathetic activation? A pilot study before and after heart transplantation, 422

Decreased heart rate variability in survivors of sudden cardiac death not associated with coronary artery disease, 16

Heart rate variability and clinical cardiology: editorial, 3

Heart rate variability and its relation to ventricular arrhythmias in congestive heart failure, 322

Power spectrum analysis of heart rate variability: a tool to explore neural regulatory mechanisms: editorial, 1

Progressive reduction of heart rate variability with eventual sudden death in two patients, 87

Temporal influences on the prediction of postinfarction mortality by heart rate variability: a comparison with the left ventricular ejection fraction, 521

#### Heart transplantation

Can power spectral analysis of heart rate variability identify a high risk subgroup of congestive heart failure patients with excessive sympathetic activation? A pilot study before and after heart transplantation, 422

Effect of beta blockade on the neurohumoral and cardiopulmonary response to dynamic exercise in cardiac transplant recipients, 431

Helicobacter pylori infection, Relation of Helicobacter pylori infection and coronary heart disease, 437

Hepatic portal venous flow, Hepatic portal venous flow in patients undergoing tricuspid valve surgery, 354

HLA antigens, Do specific HLA antigens predispose to ischaemic heart disease or idiopathic dilated cardiomyopathy?, 76

Hormone replacement therapy, Coronary heart disease, the menopause, and hormone replacement therapy, 213

Hypotension, Significant hypotension in patients given midazolam before transoesophageal echocardiography, S36 abs

Indexing, Indexing the British Heart Journal: choice of keywords, 212 Infarct size

Fatty-acid-binding protein as a plasma marker for the estimation of myocardial infarct size in humans, 135

Ten year mortality in relation to original size of myocardial infarct: results from the Gothenburg metoprolol study, 238

Infarct zone, Assessment of reperfusion of the infarct zone after acute myocardial infarction by serial cardiac troponin T measurements in serum, 242

#### Insulin

Insulin in ischaemic heart disease: are associations explained by triglyceride concentrations? The Caerphilly prospective study, 293

Insulin resistance syndrome as a feature of cardiological syndrome X in non-obese men, 41

Lewis phenotypes, insulin resistance, and risk of ischaemic heart disease: editorial, 305

Interleukin 2, recombinant, Impaired left ventricular filling rate induced by treatment with recombinant interleukin 2 for advanced cancer, 166

International Primary Pulmonary Hypertension Study, International Primary Pulmonary Hypertension Study: letter, 303

Intravascular ultrasound imaging, Intravascular ultrasound imaging of angiographically normal coronary arteries: a prospective study in vivo. 572

Ischaemic cardiomyopathy, Presence of myocardial viability does not predict global improvement in left ventricular function in chronic ischaemic cardiomyopathy, S31 abs

#### Ischaemic heart disease

Direct access exercise electrocardiography: a new service that improves the management of suspected ischaemic heart disease in the community, 531

Do specific HLA antigens predispose to ischaemic heart disease or idiopathic dilated cardiomyopathy?, 76

Insulin in ischaemic heart disease: are associations explained by triglyceride concentrations? The Caerphilly prospective study, 293

Lewis phenotypes, insulin resistance, and risk of ischaemic heart disease: editorial, 305

Significance of raised plasma concentrations of tissue-type plasminogen activator and plasminogen activator inhibitor in patients at risk from ischaemic heart disease: review, 504

**Isovolumic relaxation**, Measurement of isovolumic relaxation time by Doppler and dual M-mode techniques: comparison and pitfalls, **S33** abs

#### K

Keywords, Indexing the British Heart Journal: choice of keywords, 212

#### Ι

Left coronary artery, anomalous origin from pulmonary trunk, Successful operation in an old survivor of anomalous origin of the left coronary artery from the pulmonary trunk (Bland-White-Garland syndrome), 193

#### Left ventricle

Impaired left ventricular filling rate induced by treatment with recombinant interleukin 2 for advanced cancer, 166

Incidence and prognosis of obstruction of the left ventricular outflow tract in Liverpool (1960-91): a study of 313 patients, 588

Long-term function in the remote region after myocardial infarction: importance of significant coronary stenoses in the non-infarct-related artery, 249

On-line echocardiographic automatic boundary detection assessment of left ventricular cardiac contractility, \$33 abs

Presence of myocardial viability does not predict global improvement in left ventricular function in chronic ischaemic cardiomyopathy, S31 abs

QT interval dispersion in chronic heart failure and left ventricular hypertrophy: relation to autonomic nervous system and Holter tape abnormalities, 268

Relative effects of left ventricular mass and conduction disturbance on activation in patients with pathological left ventricular hypertrophy, 548

Temporal influences on the prediction of postinfarction mortality by heart rate variability: a comparison with the left ventricular ejection fraction, 521

The effect of successful coronary angioplasty on left ventricular compliance, \$34 abs

Lewis phenotypes, Lewis phenotypes, insulin resistance, and risk of ischaemic heart disease: editorial, 305

Lp(a) lipoprotein, Serum Lp(a) lipoprotein concentration and outcome of thrombolytic treatment for myocardial infarction, 316

#### м

M-mode techniques, Measurement of isovolumic relaxation time by Doppler and dual M-mode techniques: comparison and pitfalls, S33

Magnarail system, A randomised comparison of the Omniflex and Magnarail systems in recanalisation of coronary occlusions, 378

Magnesium sulphate, Investigation of the effects of intravenous magnesium sulphate on cardiac rhythm in acute myocardial infarction, 141

Magnetic resonance imaging, Is magnetic resonance imaging superior to transoesophageal echocardiography in the follow up of patients with thoracic aortic dissection? S35 abs

Menopause, Coronary heart disease, the menopause, and hormone replacement therapy, 213

Metolazone, Combination diuretic treatment in severe heart failure, 146
Metoprolol, Ten year mortality in relation to original size of myocardial
infarct: results from the Gothenburg metoprolol study, 238

### Microvascular dysfunction

Does X equal endothelial dysfunction? abstracts in cardiology, 181

Evidence of impaired endothelium-dependent coronary vasodilatation in patients with angina pectoris and normal coronary angiograms: abstracts in cardiology, 181

Midazolam, Significant hypotension in patients given midazolam before transoesophageal echocardiography, \$36 abs

#### Mitral regurgitation

Does papillary muscle ischaemia cause 'dynamic' mitral regurgitation? \$32 abs

Myocardial ischaemia during dobutamine stress echocardiography induces 'dynamic' mitral regurgitation, \$31 abs

#### Mitral valve

Assessment of rheumatic mitral valves: single-plane versus biplane transoesophageal echocardiography, S36 abs

Echocardiographic assessment of the mitral valve does not predict clinically useful balloon dilatation, \$36 abs

Late clinical and echocardiographic follow up after percutaneous balloon dilatation of the mitral valve, 454

Mitral valve hypoplasia in children with isolated coarctation of the

aorta, 358

Mitral valve repair: a clinical and echocardiographic study, 51

Papillary fibroelastoma of the mitral valve: a rare cause of transient neurological deficits, 6

Monitoring, Monitoring myocardial damage in cardiac surgery by troponin T detection: letter, 109

Monophasic action potential, Differential effect of pharmacological autonomic blockade on some electrophysiological properties of the human ventricle and atrium, 34

Mortality, Temporal influences on the prediction of postinfarction mortality by heart rate variability: a comparison with the left ventricular ejection fraction. 521

Muscular false tendons, Muscular false tendons, aberrant left ventricular papillary musculature, and severe electrocardiographic repolarisation abnormalities: a new syndrome, 187

Myocardial bridging, Abnormal ventricular repolarisation in association with myocardial bridging, 366

#### Myocardial infarction

Ambulatory ST segment monitoring after myocardial infarction: editorial. 113

Assessment of ejection fraction by echocardiographic automatic boundary detection following myocardial infarction: comparison with radionuclide angiography, \$33 abs

Assessment of reperfusion of the infarct zone after acute myocardial infarction by serial cardiac troponin T measurements in serum, 242

Comparison of the value of novel rapid measurement of myoglobin, creatine kinase, and creatine kinase-MB with the electrocardiogram for the diagnosis of acute myocardial infarction, 311

Does pain relief with spinal cord stimulation for angina conceal myocardial infarction?, 419

Fatty-acid-binding protein as a plasma marker for the estimation of myocardial infarct size in humans, 135

Importance of thrombosis and thrombolysis in silent ischaemia: comparison of patients with acute myocardial infarction and unstable angina, 151

Investigation of the effects of intravenous magnesium sulphate on cardiac rhythm in acute myocardial infarction, 141

Long-term function in the remote region after myocardial infarction: importance of significant coronary stenoses in the non-infarct-related artery, 249

Serum cholesterol and acute myocardial infarction: a case-control study from the GISSI-2 trial, 468

Serum Lp(a) lipoprotein concentration and outcome of thrombolytic treatment for myocardial infarction, 316

Should angiotensin converting enzyme (ACE) inhibitors be used routinely after infarction? Perspectives from the Survival and Ventricular Enlargement (SAVE) Trial: review, 115

Temporal influences on the prediction of postinfarction mortality by heart rate variability: a comparison with the left ventricular ejection fraction, 521

Ten year mortality in relation to original size of myocardial infarct: results from the Gothenburg metoprolol study, 238

Transmitral flow pattern during short exercise: a predictor of ventricular contractile reserve following myocardial infarction, \$32 abs

Will serum enzymes and other proteins find a clinical application in the early diagnosis of myocardial infarction? viewpoint, 309

#### Myocardial ischaemia

Angiotensin converting enzyme inhibition in chronic stable angina: effects on myocardial ischaemia and comparison with nifedipine, 30 Differences in autonomic nerve function in patients with silent and symptomatic myocardial ischaemia, 22

Effects of spinal cord stimulation on myocardial ischaemia during daily life in patients with severe coronary artery disease, 413

Influence of the autonomic nervous system on circadian patterns of myocardial ischaemia: comparison of stable angina with the early postinfarction period, 329

Myocardial ischaemia during dobutamine stress echocardiography induces 'dynamic' mitral regurgitation, S31 abs

Myocardial perfusion imaging, Relations between resting ventricular long axis function, the electrocardiogram, and myocardial perfusion imaging in syndrome X, 541

Myoglobin, Comparison of the value of novel rapid measurement of myoglobin, creatine kinase, and creatine kinase-MB with the electrocardiogram for the diagnosis of acute myocardial infarction, 311

#### N

Neonatal period, Changes in pulmonary venous flow pattern during early neonatal life, 182

Neural regulatory mechanisms, Power spectrum analysis of heart rate variability: a tool to explore neural regulatory mechanisms: editorial. 1

Neuropeptide Y, Cardiac neuropeptide Y and noradrenaline balance in patients with congestive heart failure, 261

Nifedipine, Angiotensin converting enzyme inhibition in chronic stable angina: effects on myocardial ischaemia and comparison with nifedipine, 30

Nitrates, Implication of prescriptions for nitrates: 7 year follow up of patients treated for angina in general practice, 38

Nitric oxide, Effect of inhaled nitric oxide on raised pulmonary vascular resistance in children with congenital heart disease, 282

Noonan's cardiomyopathy, Noonan's cardiomyopathy: a nonhypertrophic variant, 561

Noradrenaline, Cardiac neuropeptide Y and noradrenaline balance in patients with congestive heart failure, 261

Notices, 112, 208, 304, 400, 596

o

Oedema, Pathogenesis of oedema in chronic severe anaemia: letter, 490 Omniflex system, A randomised comparison of the Omniflex and Magnarail systems in recanalisation of coronary occlusions, 378

Oxygen consumption, Short-term effects of right atrial, right ventricular apical, and atrioventricular sequential pacing on myocardial oxygen consumption and cardiac efficiency in patients with coronary artery disease, 536

P

# Pacemaker, pacing

Does pacing help in vasovagal syncope?, 385

Impact of internal audit on pacemaker prescription and the immediate costs of pacing in the Northern Region: towards implementation of the recommendations of the British Pacing and Electrophysiology Group, 395

Mechanical, but not infective, pacemaker erosion may be successfully managed by re-implantation of pacemakers, 202

Mechanism of pacemaker induced cough, 484

Permanent pacing for cardioinhibitory malignant vasovagal syndrome, 274

Short-term effects of right atrial, right ventricular apical, and atrioventricular sequential pacing on myocardial oxygen consumption and cardiac efficiency in patients with coronary artery disease, 536

Successful treatment by balloon venoplasty and stent insertion of obstruction of the superior vena cava by an endocardial pacemaker lead, 363

Survey of the attitudes of British physicians to pacing, 96

Use of an implantable cardioverter defibrillator in a patient with a rate responsive pacemaker, 191

Ventricular tachycardia: an unusual pacemaker-mediated tachycardia, 481

Papillary fibroelastoma, Papillary fibroelastoma of the mitral valve: a rare cause of transient neurological deficits, 6

Papillary muscle ischaemia, Does papillary muscle ischaemia cause 'dynamic' mitral regurgitation? \$32 abs

Papillary musculature, Muscular false tendons, aberrant left ventricular papillary musculature, and severe electrocardiographic repolarisation abnormalities: a new syndrome, 187

Parasympathetic activity, Cardiac parasympathetic activity in severe uncomplicated coronary artery disease, 515

Patent foramen ovale

Assessment of changes in blood flow through the lungs and foramen ovale in the normal human fetus with gestational age: a prospective Doppler echocardiographic study, 232

Effects of a patent foramen ovale on arterial saturation during exercise and on cardiovascular responses to deep breathing, Valsalva manoeuvre, and passive tilt: relation to history of decompression illness in divers, 229

Patent foramen ovale in adult life: editorial, 209

Percutaneous balloon dilatation, Late clinical and echocardiographic follow up after percutaneous balloon dilatation of the mitral valve, 454

#### Percutaneous transluminal coronary angioplasty

Effect of successful coronary angioplasty on left ventricular compliance, S34 abs

Failure of epoprostenol (prostacyclin, PGI2) to inhibit platelet aggregation and to prevent restenosis after coronary angioplasty, 7

Randomised comparison of the Omniflex and Magnarail systems in recanalisation of coronary occlusions, 378

Temporary stent as a bail-out device during percutaneous transluminal coronary angioplasty: preliminary clinical experience, 372

Verapamil treatment after coronary angioplasty in patients at high risk of recurrent stenosis, 254

Plasminogen activator inhibitor, Significance of raised plasma concentrations of tissue-type plasminogen activator and plasminogen activator inhibitor in patients at risk from ischaemic heart disease: review, 504

Pre-excited atrial fibrillation, Haemodynamic deterioration after treatment with adenosine, 569

Pregnancy, Outcome of pregnancy in women with valve prostheses,

Prenatal diagnosis, Coarctation of the aorta: difficulties in prenatal diagnosis, 70

Primary pulmonary hypertension, International Primary Pulmonary Hypertension Study: letter, 303 Propranolol, Differential effect of pharmacological autonomic blockade on some electrophysiological properties of the human ventricle and atrium, 34

Proximal coronary arteries, Transoesophageal echo imaging and flow measurements in the proximal coronary arteries: do more planes = more success? \$35 abs

Pulmonary arteriovenous malformation, Transcatheter coil embolisation of a pulmonary arteriovenous malformation in a neonate, 370

Pulmonary atresia, Stenting of stenosed aortopulmonary collaterals: a new approach to palliation in pulmonary atresia with multifocal aortopulmonary blood supply, 487

Pulmonary oedema, Acute pulmonary oedema: an unusual clinical presentation of unruptured sinus of Valsalva, 29

Pulmonary valve atresia, Maldevelopment of conotruncal and aortopulmonary septum with absent left central pulmonary artery: anatomical and clinical implications, 89

Pulmonary vascular resistance, Effect of inhaled nitric oxide on raised pulmonary vascular resistance in children with congenital heart disease, 282

Pulmonary venous flow pattern, Changes in pulmonary venous flow pattern during early neonatal life, 182

QRS duration, Relative effects of left ventricular mass and conduction disturbance on activation in patients with pathological left ventricular hypertrophy, 548

QT interval, Errors in manual measurement of QT intervals, 386

QT interval dispersion

QT dispersion: review, 508

QT interval dispersion: a non-invasive marker of susceptibility to arrhythmia in patients with sustained ventricular arrhythmias?, 511

QT interval dispersion in chronic heart failure and left ventricular hypertrophy: relation to autonomic nervous system and Holter tape abnormalities, 268

R

Recanalisation, A randomised comparison of the Omniflex and Magnarail systems in recanalisation of coronary occlusions, 378

Restenosis

Failure of epoprostenol (prostacyclin, PGI2) to inhibit platelet aggregation and to prevent restenosis after coronary angioplasty: results of a randomised placebo controlled trial, 7

Verapamil treatment after coronary angioplasty in patients at high risk of recurrent stenosis, 254

Rhabdomyomas, 10 year review of cardiac tumours in childhood: *letter*, 490

Rheumatic mitral valves, Assessment of rheumatic mitral valves: single-plane versus biplane transoesophageal echocardiography, S36 abs

Right atrial mass, Evaluation of right atrial mass lesions using transoesophageal echocardiography, \$35 abs

Right ventricular outflow tract, False aneurysm of the right ventricular outflow tract after total correction of tetralogy of Fallot: diagnosis by echocardiography and successful repair by neck cannulation for cardiopulmonary bypass, 566

Risk factors, Coronary artery surgery in women compared with men: analysis of coronary risk factors and in-hospital mortality in a single centre, 408

Risk stratification, Heart rate variability and clinical cardiology: editorial, 3

S

Saphenous vein, Is thickening of the basal lamina in the saphenous vein a hallmark of smoking?, 45

Secundum atrial septal defect

Natural history of secundum atrial septal defect in adults after medical or surgical treatment: a historical prospective study, 224

Secundum atrial septal defect: routine surgical treatment is not of proven benefit: review, 219

Shunting, Medium-term follow up of residual shunting and potential complications after transcatheter occlusion of the ductus arteriosus, 63

#### Silent ischaemia

Differences in autonomic nerve function in patients with silent and symptomatic myocardial ischaemia, 22

Importance of thrombosis and thrombolysis in silent ischaemia: comparison of patients with acute myocardial infarction and unstable angina, 151

#### Sinus of Valsalva

Acute pulmonary oedema: an unusual clinical presentation of unruptured sinus of Valsalva, 29

Transcatheter closure of a ruptured aneurysm of the sinus of Valsalva, 479

Smoking, Is thickening of the basal lamina in the saphenous vein a hall-mark of smoking?, 45

# Spinal cord stimulation

Does pain relief with spinal cord stimulation for angina conceal

myocardial infarction?, 419

Effects of spinal cord stimulation on myocardial ischaemia during daily life in patients with severe coronary artery disease, 413

ST segment, Ambulatory ST segment monitoring after myocardial infarction: editorial. 113

Staffing, Eighth survey of staffing in cardiology in the United Kingdom 1992, 492

#### Stent, stenting

Stenting of stenosed aortopulmonary collaterals: a new approach to palliation in pulmonary atresia with multifocal aortopulmonary blood supply, 487

Successful treatment by balloon venoplasty and stent insertion of obstruction of the superior vena cava by an endocardial pacemaker lead, 363

Temporary stent as a bail-out device during percutaneous transluminal coronary angioplasty: preliminary clinical experience, 372

Streptokinase antibodies, Are streptokinase antibodies clinically important? *letter*, 303

#### Sudden death

Decreased heart rate variability in survivors of sudden cardiac death not associated with coronary artery disease, 16

Progressive reduction of heart rate variability with eventual sudden death in two patients, 87

Temporal influences on the prediction of postinfarction mortality by heart rate variability: a comparison with the left ventricular ejection fraction, 521

Superior vena cava, Successful treatment by balloon venoplasty and stent insertion of obstruction of the superior vena cava by an endocardial pacemaker lead, 363

Surgery, Surgery for atrial fibrillation: editorial, 501

Sympathetic activation, Can power spectral analysis of heart rate variability identify a high risk subgroup of congestive heart failure patients with excessive sympathetic activation? A pilot study before and after heart transplantation, 422

#### Syncope

Exercise induced vasodepressor syncope, 554

Increase in plasma beta endorphins precedes vasodepressor syncope, 446: correction, 597

#### Syndrome X

Does X equal endothelial dysfunction? abstracts in cardiology, 181

Evidence of impaired endothelium-dependent coronary vasodilatation in patients with angina pectoris and normal coronary angiograms: abstracts in cardiology, 181

Insulin resistance syndrome as a feature of cardiological syndrome X in non-obese men, 41

Relations between resting ventricular long axis function, the electrocardiogram, and myocardial perfusion imaging in syndrome X, 541

#### Γ

#### **Tetralogy of Fallot**

Complete atrioventricular septal defect with tetralogy of Fallot: diagnosis and management, 579

End-on aortogram: improved identification of important coronary artery anomalies in tetralogy of Fallot, 102

False aneurysm of the right ventricular outflow tract after total correction of tetralogy of Fallot: diagnosis by echocardiography and successful repair by neck cannulation for cardiopulmonary bypass, 566

Thallium stress imaging, Dipyridamole is superior to dobutamine for thallium stress imaging, 129

# Thoracic aortic dissection

Is magnetic resonance imaging superior to transoesophageal echocardiography in the follow up of patients with thoracic aortic dissection? \$35 abs

Transoesophageal echocardiography is the only diagnostic test required in the management of patients with acute thoracic aortic dissection, \$35 abs

Three-dimensional echocardiography, Dynamic three-dimensional echocardiography with a computed tomography imaging probe: initial clinical experience with transthoracic application in infants and children with congenital heart defects, 462

# Thrombolysis

Are streptokinase antibodies clinically important? *letter*, 303

Importance of thrombosis and thrombolysis in silent ischaemia: comparison of patients with acute myocardial infarction and unstable angina, 151

Serum Lp(a) lipoprotein concentration and outcome of thrombolytic treatment for myocardial infarction, 316

Thrombosis, Importance of thrombosis and thrombolysis in silent ischaemia: comparison of patients with acute myocardial infarction and unstable angina, 151

**Tissue-type plasminogen activator**, Significance of raised plasma concentrations of tissue-type plasminogen activator and plasminogen activator inhibitor in patients at risk from ischaemic heart disease: *review*, 504

Transcatheter closure, Transcatheter closure of a ruptured aneurysm of the sinus of Valsalva, 479

**Transcatheter coil embolisation,** Transcatheter coil embolisation of a pulmonary arteriovenous malformation in a neonate, 370

Transcatheter occlusion, Medium-term follow up of residual shunting and potential complications after transcatheter occlusion of the ductus arteriosus, 63

Transmitral flow pattern, Transmitral flow pattern during short exercise: a predictor of ventricular contractile reserve following myocardial infarction, S32 abs

#### Transoesophageal echocardiography

Assessment of rheumatic mitral valves: single-plane versus biplane transoesophageal echocardiography, S36 abs

Evaluation of right atrial mass lesions using transoesophageal echocardiography, \$35 abs

How transoesophageal echocardiography can assist cardiac surgery in adults: editorial, 404

Is magnetic resonance imaging superior to transoesophageal echocardiography in the follow up of patients with thoracic aortic dissection? \$35 abs

Setting up a transoesophageal echocardiography service, \$15

Significant hypotension in patients given midazolam before transoesophageal echocardiography, S36 abs

Transoesophageal echo imaging and flow measurements in the proximal coronary arteries: do more planes = more success? S35 abs

Transoesophageal echocardiography is the only diagnostic test required in the management of patients with acute thoracic aortic dissection, \$35 abs

Value of multiplane transoesophageal echocardiography in recurrent atrial myxoma, 540

Trent Region, Variations in the use of coronary angiography in three cities in the Trent Region, 474

**Triage**, Telephone triage of cardiac emergency calls by dispatchers: a prospective study of 1386 emergency calls, 440

Tricuspid valve surgery, Hepatic portal venous flow in patients undergoing tricuspid valve surgery, 354

**Triglycerides**, Insulin in ischaemic heart disease: are associations explained by triglyceride concentrations? The Caerphilly prospective study, 293

#### Troponin T

Assessment of reperfusion of the infarct zone after acute myocardial infarction by serial cardiac troponin T measurements in serum, 242

Monitoring myocardial damage in cardiac surgery by troponin T detection: letter, 109

Tumours, 10 year review of cardiac tumours in childhood: letter, 490

IJ

Ultrasound, Intravascular ultrasound imaging of angiographically normal coronary arteries: a prospective study in vivo, 572

# v

#### Valve prostheses

Doppler echocardiographic assessment of early changes in diastolic function after aortic valve replacement for aortic stenosis, \$34 abs

Outcome of pregnancy in women with valve prostheses, 196

Vasodepressor syncope, Increase in plasma beta endorphins precedes vasodepressor syncope, 446: correction, 597

Vasovagal syncope, Does pacing help in vasovagal syncope?, 385

Vasovagal syndrome, Permanent pacing for cardioinhibitory malignant vasovagal syndrome, 274

#### Ventricular arrhythmias

Heart rate variability and its relation to ventricular arrhythmias in congestive heart failure. 322

QT dispersion: review, 508

QT interval dispersion: a non-invasive marker of susceptibility to arrhythmia in patients with sustained ventricular arrhythmias?, 511

Ventricular long axis function, Relations between resting ventricular long axis function, the electrocardiogram, and myocardial perfusion imaging in syndrome X, 541

Ventricular repolarisation, Abnormal ventricular repolarisation in association with myocardial bridging, 366

Ventricular stimulation, Who needs ventricular stimulation studies? editorial, 307

Ventricular tachycardia, Ventricular tachycardia: an unusual pacemaker-mediated tachycardia, 481

Verapamil, Verapamil treatment after coronary angioplasty in patients at high risk of recurrent stenosis, 254

Video review, British Heart Foundation. A gift of life, 399

#### W

Wegener's granulomatosis, Wegener's granulomatosis and the heart, 82

## Women

Coronary artery surgery in women compared with men: analysis of coronary risk factors and in-hospital mortality in a single centre, 408 The rights of women: editorial, 401